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BLUE CROSS AND MEDICAL SERVICE PLANS



FEDERAL SECURITY AGENCY

U. S. PUBLIC HEALTH SERVICE

WASHINGTON, D. C.

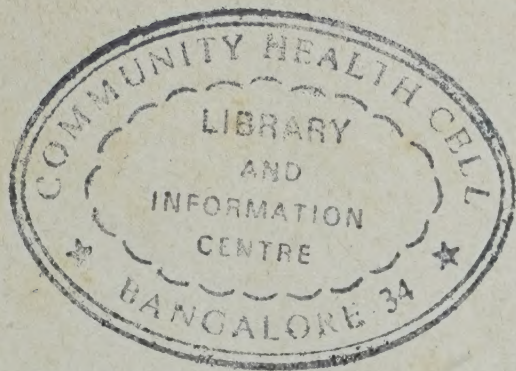
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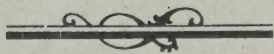
**BLUE CROSS AND
MEDICAL SERVICE PLANS**

by

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**FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
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CHAPTER i

INTRODUCTION: SCOPE, PURPOSE AND METHOD OF SURVEY

Within the last decade there has been a rapid development of voluntary health insurance in the United States. As of January 1, 1947 approximately 39,700,000 people -- more than one out of every four persons in the population -- were enrolled in organizations providing hospital service on a prepayment basis or had insurance protection against the cost of this service. Of these about 16,100,000 were also covered for physicians' services in surgical and obstetrical cases and of the latter number about 5,000,000 were also covered for physicians' services for medical cases in the hospital. About 3,700,000 persons were covered for office and home services, most, though not all of whom, were covered for the other services.

TYPES OF VOLUNTARY HEALTH INSURANCE ORGANIZATIONS

The types of organizations providing health services on a prepayment basis or furnishing insurance against the costs of these services are briefly described below. Table 1 shows the number of people covered for designated services by each type.

BLUE CROSS HOSPITAL SERVICE PLANS

From the standpoint of the number of participants, the leading type of existing prepayment or insurance plans is the Blue Cross hospital service plans. The distinguishing features of these plans are that they are non-profit, that the subscriber has free choice among the hospitals of the area, that they are sponsored or endorsed by the hospitals of the area, that they operate through contracts with the member hospitals which in return for specified payments agree to provide specified services to subscribers, and finally that the plans meet the standards of and are approved by the American Hospital Association. The Blue Cross plan movement, from its beginning in 1932, has grown with great rapidity. On January 1, 1947 there were 24,250,000 persons enrolled in the 81 plans in the United States.

A few Blue Cross plans have expanded their services to include certain types of physicians' services, mainly surgery and obstetrical service. Nine plans have done this and 604,000 of their members are enrolled for these latter services.

MEDICAL SERVICE PLANS

Closely allied with hospital service plans are the non-profit, free-choice medical service plans, sponsored by medical societies. The major development of these plans has come since 1939. As of January 1, 1947 there were

TABLE I

Types of Organizations Providing Health Services on a Prepayment Basis or Insurance Against the Costs of Such Services, and Number of Persons Covered for Designated Services, January 1, 1947
(Continental United States)

TYPE OF ORGANIZATION	SERVICES COVERED			
	HOSPITALIZATION	PHYSICIANS' SERVICES		
		SURGERY AND OBSTETRICS	MEDICAL CASES IN THE HOSPITAL	OFFICE AND HOME VISITS
BLUE CROSS HOSPITAL SERVICE OR JOINT HOSPITAL-MEDICAL SERVICE PLANS	24,250,000	604,000	135,000	-
MEDICAL SERVICE PLANS SPONSORED BY MEDICAL SOCIETIES AND/OR AFFILIATED WITH BLUE CROSS PLANS	452,000	3,832,000	1,704,000	513,000
INSURANCE COMPANIES ^{1/}	12,500,000	9,300,000	850,000	750,000
INDUSTRIAL MEDICAL PLANS ^{2/}	1,435,000	1,395,000	1,342,000	1,394,000
FARMERS HOME ADMINISTRATION PLANS ^{2/}	134,000 ^{4/}	164,000 ^{5/}	166,000 ^{6/}	166,000 ^{6/}
PRIVATE GROUP CLINICS	375,000	388,000	406,000	328,000
CONSUMER SPONSORED PLANS	194,000	181,000	182,000	315,000
UNIVERSITY HEALTH SERVICES	100,000	100,000	100,000	100,000
OTHER	250,000	100,000	100,000	100,000
TOTAL	39,690,000 ^{7/}	16,064,000 ^{7/}	4,985,000 ^{7/}	3,666,000 ^{7/}

TABLE I (Cont'd.)

- 1/ Based on assumption of 2 1/2 dependents per employee with dependent coverage.
- 2/ Data as of January - May 1945. Includes plans for employees of governmental agencies. The figures presented are to be regarded as minimums. Undoubtedly some plans were missed in the canvass.
- 3/ Data as of June 30, 1946. Includes the experimental plans for farm families established by the Department of Agriculture.
- 4/ Does not include 67,000 persons covered through enrollment in Blue Cross plans.
- 5/ Covered for surgery only. Does not include approximately 3,000 persons covered through enrollment in medical plans.
- 6/ Includes obstetrical care.
- 7/ In general each total is included within the total to the left, i. e., virtually all of those covered for physicians' services for medical cases in the hospital are also covered for surgery and obstetrics, and virtually all of those covered for the latter services are also covered (through the same or another type of plan) for hospitalization. Most, though not all, of those covered for home and office visits are also covered for the other services.

SOURCES:

Figures on participants in hospital and medical service plans are based on data of the Blue Cross Commission.

The number of persons having protection through insurance companies is based on data from a survey by the Life Insurance Association of America showing number of employees and dependents covered under group insurance as of December 31, 1945. These figures were adjusted for increase during 1946 on the basis of data from five principal companies, and to the totals for group business thus arrived at was added the estimated coverage under individual policies. See Appendix K.

The data on persons covered under industrial medical plans are from *Prepayment Medical Care Organizations* by Margaret C. Klem (Bureau Memorandum No. 55, Third Edition, Bureau of Research and Statistics, Social Security Board, June 1945).

Data on enrollment in the Farmers Home Administration plans were obtained directly from that organization. The figures for private group clinics and consumer sponsored plans are from *Prepayment Medical Care Organizations*.

Figures for university health services are token estimates only. No recent satisfactory data are available. The figures on the coverage of "other" plans or organizations are estimates based on the known coverage of a few organizations in this category.

33 plans^{1/} (other than those fully integrated with hospital service plans, with a total enrollment of 3,832,000.^{2/} New plans are currently being organized in many localities or States. Most of the medical service plans cover either surgical and obstetrical service only, or these services and physicians' services for hospitalized medical cases. Only a few cover physicians' service in the office and home, and generally such coverage is restricted to employed persons. All of the separate medical plans, with four exceptions, are jointly operated with the hospital service plans of their areas in that the hospital service plan enrolls new subscribers, collects subscription charges and maintains subscriber records for the medical plan, or there is joint control over these activities. The four exceptions are the plans in Washington, Oregon, northern California and Pennsylvania, which have no relationships with the hospital service plans serving the areas. The first three of these provide physicians' services and hospitalization.

HOSPITAL, SURGICAL AND MEDICAL INSURANCE BY INSURANCE COMPANIES

Within the past ten years there has been a considerable development of commercial insurance providing indemnification against, or reimbursement of, expenses incurred for medical care. It is estimated that, as of January 1, 1947, approximately 12,500,000 persons were covered for hospital care and about 9,300,000 for surgical and obstetrical service. Coverage of physicians' services, other than surgical and obstetrical service, is relatively new and largely experimental and probably not more than 850,000 people had this coverage.

This insurance is sold on both a group and individual basis. About 75 percent of the persons protected are insured on a group basis, i.e., through group contracts with the employer. Most of the group insurance has been written by the large life insurance companies which sell group life and disability insurance and until recently was only sold by these companies in conjunction with these other types of insurance. Hospital and surgical indemnity insurance is sold on an individual basis by a large number of companies, mainly casualty companies offering accident and health insurance.

The estimated number of persons insured against hospital, surgical and medical costs by insurance companies includes only those persons whose policies afford an appreciable degree of coverage against the risk. There are many millions of persons holding commercial "health and accident" policies providing for weekly or monthly payments, often \$50 or \$100 a month, in the event of disability due to illness or accident or to accident alone. Many of these policies provide that an extra payment, usually one-half of the regular indemnity, will be paid for any period during which the policy holder is in a hospital. In most instances this would mean that the policy holder would be entitled to about \$1.00 or a \$1.50 for each day in the hospital -- a payment so small as to mean negligible coverage of the hospital bill.

INDUSTRIAL MEDICAL SERVICE PLANS

Over 100 industrial, railroad and mining companies have established

^{1/} The numerous county medical society plans in Washington are here considered as if they were one plan. Similarly, the various plans in Oregon are considered as one plan.

^{2/} Includes two plans not sponsored by medical societies but affiliated with Blue Cross plans.

their own plans for providing medical care to their employees and in some cases to the dependents of employees. In most instances service is provided by staffs of salaried physicians; the companies may or may not have their own hospitals. Usually all or the major portion of the cost is borne by the employees through periodic contributions deducted from pay. Generally quite comprehensive care is furnished, i.e., hospitalization, and physicians' care in the office, home and hospital. Examples of such industrial medical service plans are those of the Tennessee Coal, Iron and Railroad Company in Birmingham, Alabama, the Endicott Johnson Company of Johnson City, New York, and the Southern Pacific Railway.

Most company medical service plans are of fairly long standing, i.e., have existed for 20 or 30 years or more. Railroad and mining companies often found it necessary to establish such plans because of the absence of other medical facilities.

A thorough canvass of these organizations by the Social Security Board in 1945 obtained information on 115 plans covering approximately 1,435,000 persons for hospitalization and slightly smaller numbers for other types of services.^{3/} The number of people covered by plans of this type has not increased much in recent years, and from 1943 to 1945 there was actually a small decrease.^{4/}

FARMERS HOME ADMINISTRATION PLANS

These are plans for low income farm families who are borrowers from the Administration (formerly the Farm Security Administration). The plans operate through agreements with the local hospitals, physicians and dentists. The annual dues, which vary from \$10 to \$50 depending upon the scope and costs of services, are loaned to the families and are repaid by the families during the course of the year along with the loans made for other purposes. The scope of the services provided under these plans varies widely. Some provide quite complete care: hospitalization, physicians' services, some dentistry, nursing. Others provide hospitalization only, or physicians' services only, or hospitalization and surgical services only. At one time, in 1942, these plans served over 500,000 persons; as of June 30, 1946 some 134,000^{5/} persons were covered for hospitalization and 165,000 for physicians' services.^{5/}

PRIVATE GROUP CLINICS

In a number of localities groups of physicians have established group clinics which provide care on a prepayment basis. The outstanding example of such a clinic is the Ross-Loos Medical Group in Los Angeles. Some 400,000 persons secure surgical care and physicians' services in the hospital through such organizations, a somewhat smaller number obtain other services.

^{3/} Klem, Margaret, C., Prepayment Medical Care Organizations, Bureau Memorandum No. 55, Bureau of Research and Statistics, Social Security Board, 1945.

^{4/} The same, p. 17.

^{5/} The figures do not include Farmers Home Administration borrowers enrolled in Blue Cross and medical service plans, but do include the membership in the experimental rural health programs established by the Department of Agriculture.

CONSUMER SPONSORED PLANS

In a number of localities groups of consumers have established prepayment plans for obtaining medical services. In some instances these plans have their own facilities and staffs of physicians; in other instances care is purchased from local hospitals and physicians on a fee basis. Some 315,000 persons secure physicians office and home visits through these arrangements; a smaller number are covered for other services.

UNIVERSITY HEALTH SERVICES

Many colleges and universities have developed arrangements for providing certain medical services to students, the students paying an annual fee towards the support of this service. No adequate figures on the number of students participating are available. It may be roughly estimated that at least 100,000 students secure care through these arrangements.

OTHER PLANS

A number of hospitals have prepayment plans of their own, and there are a few hospital service plans -- plans providing the services of a number of hospitals on a prepayment basis -- which are not approved Blue Cross plans. In the State of Oregon a number of commercial organizations known as "hospital associations" provide hospitalization and physicians' services on a prepayment basis. All told these plans cover about 250,000 persons for hospital care and perhaps 100,000 for physicians' services.

PURPOSE, SCOPE AND PROCEDURES OF THE SURVEY

The growth of voluntary health plans led the U.S. Public Health Service to believe that detailed knowledge of these plans would be desirable. It was decided first to undertake a survey of the Blue Cross hospital service plans and the medical service plans operated in conjunction with them since these plans had the largest number of subscribers and were growing at the fastest rate.

Accordingly, in December 1943, the Surgeon General of the United States Public Health Service wrote a letter to the director of the Blue Cross Commission (then called the Hospital Service Plan Commission) of the American Hospital Association stating the desire of the Service to make a survey of Blue Cross plans and asking whether the Commission and the plans would wish to cooperate in such an undertaking. The Commission replied that it and the Board of Trustees of the American Hospital Association would welcome such a survey and would give it their cooperation. The Commission appointed five representatives to confer with the U. S. Public Health Service in regard to the survey. In conferences between these representatives and representatives of the Service, the following statement of the purposes, procedure, and scope of the proposed survey were agreed upon:

I. Purpose of Study

The need for adequate health service to the people of America makes it desirable that the U.S. Public Health Service have an informed opinion of the present and potential usefulness of existing methods of distributing medical and hospital care.

The U.S. Public Health Service is interested in making a study to determine how well the Blue Cross Plans are now serving and may best serve public needs. Blue Cross Plans also are interested in learning how they may be made more effective. This study has been proposed in the public interest and its purpose is to appraise the advantages and limitations of Blue Cross Plans, which have enrolled thirteen million (January 1944) subscribers throughout the United States.

The Board of Trustees of the American Hospital Association and the Hospital Service Plan Commission have endorsed this study and have recommended that all Blue Cross Plans cooperate with the U. S. Public Health Service.

II. Procedures of Study

The study will include conferences with the Directors and Staffs of representative Plans and, in cooperation with the Plan Directors, conferences with representatives of the hospitals, the medical profession, and the general public in the community.

III. Scope of Study

The study will include all aspects necessary for an understanding of the Plans as individual entities and of the Blue Cross movement as a whole. This will cover the history, growth, subscription rates and benefits, contracts with hospitals, legal status, enrollment policies and problems, financial status, utilization experience, and relations with hospitals, the medical profession and the general public. It will also include data as regards inter-plan relationships and the American Hospital Association approval program.

The question of cooperation in the survey was submitted to all of the plans by the Blue Cross Commission at a conference of the plans in March 1944, and a majority of the plans voted to approve the survey. Subsequently the individual plans indicated their willingness to participate in the survey. Originally 41 of the then 71 plans in this country volunteered to be studied. Later many other plans indicated their willingness to be included so that there were few restrictions upon the choice of plans to be surveyed.

The field work of the survey was performed during the period March 1944 to February 1945. The plans visited were selected from among those willing to participate in the survey, and were chosen so as to obtain a representative sample of all plans with respect to size, geographical location, and other factors. An endeavor was made to include as many of those with affiliated medical plans as possible. In all, 39 of the hospital service plans and 17 (all but two of the then existing) medical plans were visited. (Table 3, chapter 3, gives a list of the plans and indicates those visited.) The hospital service plans surveyed had a total enrollment of over two-thirds the enrollment of all the hospital plans and the medical plans visited had an aggregate enrollment of over 95 percent of the total enrollment of these plans.

The plans were visited either singly or jointly by the writer and an assistant. ⁶/ Surveys of the plans took from two weeks in the case of the larger plans to one or two days in the case of the smaller plans. The surveys covered all aspects necessary for a proper understanding of the plan and its operation. This included data on the establishment of the plan, its history and growth, the area served, the rates charged and benefits provided, the basis and rates of payment to hospitals, the enrollment policies and problems, the legal status of the plan, how it was controlled, its financial status, its utilization experience, and its relations with the hospitals, the medical profession and the general public. Analogous data were obtained in the case of medical plans. Conferences were held with hospital superintendents, physicians and employers and with representatives of hospital councils, medical societies, labor unions, and community organizations in order to determine the attitudes of these individuals towards the plans.

Since conclusion of the formal surveys, additional data have been secured through occasional visits to plans, by attendance at plan conferences and through correspondence.

ORGANIZATION OF THE REPORT

The present report gives the findings and conclusions of this survey.

The hospital and medical service plans are closely related, being jointly administered in most cases. The close relationship between the two types of plans, which almost makes them a single phenomenon, must be kept in mind. However, for purposes of exposition it is best to discuss first the hospital plans and then the medical plans, and this will be the procedure followed.

As the survey progressed it became clear that an appraisal of the hospital and medical service plans could not be made without first-hand knowledge of hospital, surgical and medical insurance offered by commercial insurance companies. Accordingly, visits were made to six of the leading insurance companies in this field, and data were secured by correspondence from other principal companies. Appendix K contains a description of this insurance, its extent, the policies offered, rates charged, methods of selling and administration, and financial experience.

⁶/ Henry F. Vaughan, Jr.

CHAPTER 2

THE DEVELOPMENT OF HOSPITAL SERVICE PLANS

Hospital service plans arose out of a desire on the part of the public for protection against the risk of burdensome sickness costs, and a desire on the part of hospitals to meet this need of the public's and to increase and stabilize their own incomes by making it easier for the public to pay hospital bills.

Hospital service plans were by no means the first form of health prepayment or insurance plans to develop in this country. As early as the seventies and eighties a number of industrial, mining and railroad companies developed prepayment plans for providing medical care to their employees. In Washington and Oregon beginning as early as 1906 a number of so-called "hospital associations" had developed. These made contracts with employers to provide medical care for employees, first for industrial accidents and later for ordinary illness as well. Prior to the thirties a few groups of doctors here and there had started plans for providing their services on a prepayment basis.

FORERUNNERS OF COMMUNITY PLANS

The forerunners of community hospital service plans were single hospitals which developed plans for providing their own services on a prepayment basis. Such arrangements were developed as far back as 1880 by a number of hospitals in northern Minnesota. This hospital insurance was sold to lumberjacks. These plans worked satisfactorily for a while and then failed owing, it is said, to the fact that lumberjacks who had spent their money in celebrations after the spring thaw discovered that they could secure free bed and board at the hospital under their hospital contracts.

In 1921 a hospital in Grinnell, Iowa developed a plan whereby a payment of \$8.00 a year entitled the beneficiary to three weeks of hospital care, including room, board, and floor nursing, but not including the special hospital services. This plan had a few hundred subscribers and is still in operation though now restricted to local college students.

The single-hospital plan which in effect was the real father of the hospital service plan movement was the Baylor University plan. In 1929 the white school teachers of Dallas, Texas decided that they wished protection against hospital costs and approached the Baylor University hospital to see if some plan could be worked out. Dr. Justin Ford Kimball, vice president of the University, sympathized with their desire and evolved a plan whereby each teacher would be eligible for three weeks hospitalization in return for a payment of \$3.00 a semester, \$6.00 a year. Over 1500 of the school teachers became members. The experiment was successful from the point of view of both the hospital and the subscribers, and before long other employed groups in the

city requested similar privileges. Soon membership in the Baylor "group hospitalization" plan was extended to several thousand persons.

A brochure of 1930 lists the benefits. Care was provided for 21 days in a \$5.00 private or semi-private room, plus a 33-1/3 percent discount for 344 additional days. Services were quite complete including use of the operating room, anesthesia, all medicines, dressings and full laboratory service. A 50 percent discount on regular charges was allowed for maternity cases. There is no mention in the pamphlet of any maternity waiting period. Cases not ordinarily admitted to Baylor, such as tuberculosis, mental and nervous diseases, acute venereal disease and virulently contagious cases, were not covered. If a patient wished a better room a \$5.00 credit was allowed. There was no provision for service in hospitals other than the Baylor University hospital.

Administration costs of the plan were borne by the hospital. There were no age limits or enrollment percentage requirements; the only requirement was employment in a group. The school teachers were found to be a bad risk and after \$2,000 was lost on them, their rate was raised to \$8.00 a year. In 1933 coverage was extended to dependents. At the end of 1934 there were 408 groups with 23,000 persons included in the plan.

The success of the Baylor University Hospital plan stimulated other hospitals in Dallas and the southwest to start similar plans.

Encouraged by the apparent success of some of the early plans, many hospital administrators throughout the country began to develop or considered developing single hospital plans in their own institutions. However, if each hospital in a community developed its own plan the result would be competitive solicitation of subscribers, denial of freedom of choice to subscribers at the time of illness, and interference with physicians' prerogatives and practices in the care of private patients. It was soon apparent that instead of each hospital organizing its own plan, it would be far better for all the hospitals of a community to get together and jointly offer a plan. In this way the unethical and unsound features attending solicitation of patients by individual hospitals would be eliminated and subscribers would retain freedom of choice as to the hospital they desired. Soon city-wide free-choice plans made their appearance.

THE FIRST COMMUNITY PLANS

The first city-wide plan was that offered by the hospitals of Sacramento, California, in July 1932. This plan evolved out of an effort by one of the hospitals, Sutter Hospital, to provide hospital insurance to its own employees. The other hospitals in the city asked that the plan be broadened so that they could include their own employees. After some trial it was determined to make the plan available to the general public. The plan was set up as a mutual insurance company, initial capital being supplied by the hospital.

The next plan to start was in Newark, New Jersey, in January 1933. A small group of business men had decided that hospitalization insurance had commercial possibilities. They approached the secretary of the Essex County Hospital Association who later took a trip to Texas to study the Baylor University Plan. He returned a convert to the idea but certain that any plan should be established on a city-wide basis. The Hospital Council authorized a promotion agency formed by the business men to contract with employed people in Newark for hospital care. After six months the initial working

capital provided by the sales agency was returned and the Hospital Council, through its executive secretary, took over the management of the plan. In 1937 this plan became the Hospital Service Plan of New Jersey.

In July 1933 eight voluntary hospitals of St. Paul, Minnesota, offered group hospitalization to the public. These hospitals together contributed a fund of \$857 with which to start the new organization. It was this plan which in its early years developed the idea of a Blue Cross as the symbol of the movement. In 1935 the St. Paul plan was expanded to include Minneapolis and the name was changed to Minnesota Hospital Service Association.

Four other plans were also started in 1933. In Durham, North Carolina, the Watts Hospital and the Duke University Hospital agreed to back the Hospital Care Association. A plan -- subsequently discontinued or merged with a later formed plan -- was started in San Jose, California; and two plans -- both of which failed subsequently to receive approval -- were started in West Virginia.

In February 1934, the Hospital Service Association of New Orleans was started. This Association took over certain contracts of the Touro Infirmary which had had an experimental plan since 1932. In the spring of 1934 a plan was started in Washington, D. C., the initial capital being provided by the Community Chest. In July 1934, the Cleveland Hospital Service Association was launched. This plan was fostered and organized by the Cleveland Hospital Council and working capital was loaned by the Cleveland Welfare Federation.

In 1935 nine plans were started, three in New York State, one in Delaware, one in North Carolina, one in Pennsylvania, one in Tennessee, and two in Virginia.

THE FIRST ENABLING LEGISLATION

The New York plans were the first the establishment of which had to wait upon the passage of special enabling legislation. In the other States previously the groups interested in the establishment of plans had assumed that these plans did not constitute insurance but represented simply the sale of hospital service on a prepayment basis. When the attorney-generals or departments of insurance in these States had been requested for a ruling, they had ruled that group hospitalization constituted the sale of service rather than insurance, and that as such these plans could incorporate under the general incorporation laws and were exempt from the regulations covering stock and mutual insurance companies. This exemption was important since it meant that the plans would not need to make their subscribers liable for assessments, and could start without the sizable capital required of stock companies.

In New York, the State Superintendent of Insurance ruled that the projected hospital service plans would be engaging in insurance. It was therefore evident that special enabling legislation would be required if the projected plans were to be exempt from the ordinary insurance regulations. The desired legislation was proposed by civic, hospital and medical leaders and became a law on May 16, 1934.

The act stated that any corporation organized for the purpose of operating a non-profit hospital service plan should be governed by the provisions of this act, and should be exempt from all other provisions of the insurance law; that at least a majority of the directors of such corporations must be administrators or trustees of hospitals which have contracted to render service; that such organizations shall be incorporated only with the consent of

the insurance and welfare departments; that the rates charged subscribers shall be subject to the review of the insurance department and the rates of payment to hospitals subject to the approval of the welfare department; that such organizations shall render reports to and be subject to examination by the superintendent of insurance; and that every such corporation is declared to be a charitable and benevolent institution and exempt from State or local taxes other than taxes on real estate and office equipment. From this time on, in virtually all of the remaining States, the passage of somewhat similar legislation was a prerequisite for the starting of plans.

SUBSEQUENT GROWTH OF THE MOVEMENT

In 1936 eight new plans were started and by January 1st of 1937 26 plans were in operation with a total enrollment of 608,365 persons. By January 1, 1940, as Table 2 shows, there were 59 plans in this country with a total enrollment of 4,409,543. By January 1, 1942, the number of plans had risen to 66 and the number of participants to 8,399,433. On January 1, 1947, there were 81 plans in operation in this country with a total enrollment of 24,250,083.

<p>TABLE 2</p> <p>Number of and Enrollment in Approved Hospital Service Plans in the United States, 1933-1947.^{1/}</p>		
DATE	NUMBER OF PLANS	NUMBER OF PARTICIPANTS
JANUARY 1, 1933	1	2,000
" " 1934	6	11,538
" " 1935	10	54,494
" " 1936	17	214,313
" " 1937	26	608,365
" " 1938	38	1,364,975
" " 1939	48	2,874,055
" " 1940	59	4,409,543
" " 1941	65	6,012,483
" " 1942	66	8,399,433
" " 1943	74	10,215,241
" " 1944	73	12,659,313
" " 1945	75	15,747,558
" " 1946	80	18,881,222
" " 1947	81	24,250,083

^{1/} Based on data of the Blue Cross Commission. The Approval program of the American Hospital Association was not instituted until 1937 and the data for the years prior to that time included plans which subsequently did not meet the approval standards.

Blue Cross plans have also been established in Canada and Puerto Rico. On January 1, 1947, the five Canadian plans had a total enrollment of 1,593,251 and the Puerto Rico plan had an enrollment of 33,090.

In the beginning all of the plans were started as local plans serving a particular city. Some of these plans later expanded the territory served so that they served the whole State. From 1939 on, with one exception, all of the plans started in States, no part of which was previously served by a plan, have been started on a State-wide basis. In fact, the Blue Cross Commission of the American Hospital Association has definitely discouraged the starting of new plans on any other basis.

The first few plans that were started offered enrollment at first only to employed persons or provided only small discounts on the cost of care for dependents. Only gradually did the plans extend coverage to dependents, some by providing increasingly larger discounts, others by providing full benefits for dependents but at the same charge per person as for the employed subscriber. Only since 1937 or 1938 have most of the new plans initially offered full coverage of dependents at a family rate.

The increasing emphasis placed by all of the plans upon the family as the unit of enrollment is seen in the shifting proportions of subscribers and dependent participants. At the beginning of 1937, 63 percent of the total participants in all plans were subscribers and 37 percent were family participants. In January 1947, 44 percent of all participants were subscribers and 56 percent were family dependents.

SPONSORSHIP AND INITIAL FUNDS

In most cases the initiative and main drive for the starting of the various plans came from the hospitals of the community -- from hospital administrators and trustees. These persons were interested in establishing plans because they believed the plans would benefit both the hospitals and the public. The interest of hospitals in establishing plans was definitely stimulated during the depression by the financial predicament in which hospitals found themselves -- income from paying patients decreasing and demands for free care increasing. Hospitals hoped that hospital care insurance would increase and stabilize their income and cut down on the load of charity care. However, the interest of hospitals in establishing and fostering the plans did not diminish with the end of the depression but has continued unabated.

Hospital administrators and trustees were not the only ones interested in establishing plans. Civic leaders other than hospital trustees, civic organizations and the local medical profession helped. In a few cases an individual who hoped to become the executive director of the plan played a major role in promoting its establishment. The role played by various groups in the formation of a plan is usually rather definitely indicated by the interests or groups which provided the starting capital. Of the 39 plans surveyed, in 22 instances the hospitals contributed the starting capital; in six, the funds required to start were contributed by the local Community Chest or a local foundation. In the case of three plans all of the initial funds were provided by civic leaders. In five plans the funds were provided jointly by civic leaders and the hospitals, in one plan by the local medical society and the hospitals, in one plan jointly by civic leaders and the

individual who promoted the plan and became its head. One plan had no starting capital whatever except the services of its promoter and the agreement of the hospitals to accept delayed payments.

It is amazing on what small sums these plans were able to make their start. Of 35 plans for which this information was obtained, one plan had no initial capital; two plans had starting funds of less than \$1,000; 13 plans had from \$1,000 to \$5,000; seven from \$5,000 to \$10,000; four from \$10,000 to \$20,000; and eight from \$20,000 to \$30,000. None had more than \$30,000. In all or virtually all cases the starting capital was repaid when the plan was on its financial feet.

THE ROLE OF THE AMERICAN HOSPITAL ASSOCIATION

The establishment of hospital service plans was encouraged and guided by the American Hospital Association. In February 1933, the Board of Trustees of the Association adopted the following resolution:

"Resolved: That the Board of Trustees of the American Hospital Association approve the principle of hospital insurance as a practicable solution of the distribution of the cost of hospital care, which would relieve from financial embarrassment and even from disaster in the emergency of sickness those who are in receipt of limited incomes; that the Trustees, therefore, refer this subject to the Council on Community Relations and Administrative Practice for study and recommendations."

In the spring of 1933 the Council on Community Relations and Administrative Practice issued a small folder entitled "Essentials of an Acceptable Plan for Group Hospitalization." The essentials were: ¹/

1. *"Emphasis on Public Welfare"*: Group hospitalization should be organized, in principle and in fact, as a public service.
2. *"Limitation to Hospital Charges"*: The plans should cover payments for hospital care only and should not cover the professional services of physicians rendered to patients.
3. *"Enlistment of Professional and Public Interests"*: In establishing plans advice should be sought, and interest enlisted, from the medical profession, hospital trustees, and other qualified persons or groups interested in public service.
4. *"Choice of physician and Hospital"*: The subscriber's freedom to choose his physician or hospital should remain unchanged.
5. *"Non-Profit Organization"*: Group hospitalization plans should be organized and introduced on a non-profit basis. No individual or group should be allowed to enjoy any financial gain from a plan, other than a reasonable and proper return for necessary services.
6. *"Economic Soundness"*: Each plan should be economically sound with regard to such details as subscription rates, scope of benefits, remuneration of hospitals, eligibility of subscribers and accumulation of reserves.
7. *"Cooperative and Dignified Promotion"*: Plans should encourage participation by all hospitals of standing in the community. The ultimate responsibility should be assumed by the participating hospitals which should agree to render service to subscribers in exchange for the subscriptions

¹/ The summaries of the essentials are our own.

collected. The plans should be introduced in a dignified manner, in keeping with the professional ideals of hospital service. Publicity should be limited to the plan itself rather than to participating hospitals.

In the autumn of 1932 the Council on Community Relations and Administrative Practice of the Association requested Dr. C. Rufus Rorem of the staff of the Julius Rosenwald Fund to act as its consultant on group hospitalization. His first act was to draft the "Essentials" previously referred to. Dr. Rorem spent an increasing portion of his time in providing consultation and advice to groups interested in starting plans and in serving as a central clearing house of information for the plans. In September 1936 the Julius Rosenwald Fund, recognizing the potential importance of the development of group hospitalization, granted a request from the American Hospital Association to establish the Commission on Hospital Service (first called the Committee on Hospital Service) at the headquarters of the Association with Dr. Rorem as full time director. ^{2/} After the expiration of a five-year Rosenwald grant, the work of the Commission was financed by the plans themselves.

The functions of the newly formed Commission were stated early in 1937 to be as follows:

- (a) "to provide information and advice to hospitals or communities contemplating the establishment of voluntary hospital care insurance plans."
- (b) "to serve as a clearing house of information for the executives of existing hospital service associations."
- (c) "to study other related problems of hospital administration and finance."

Among the first activities of the new Commission was the calling of a national meeting of executives of non-profit hospital service plans in Chicago, in February 1937. This gathering set the precedent for regular meetings of hospital service plans. At this same meeting it was announced that the trustees of the American Hospital Association had authorized associate institutional membership in the Association for any non-profit plan. Out of this action developed the present approval program, i.e., the approval of plans meeting specified standards for membership in the Association. Approval entitles the plan to use the Blue Cross symbol and to call itself a Blue Cross plan.

^{2/} The name of the Commission was subsequently changed to Hospital Service Plan Commission and in January 1948 to Blue Cross Commission.

CHAPTER 3

PRESENT PLANS, AND AREA AND POPULATION SERVED

As of January 1, 1947 there were 81 approved Blue Cross plans in the continental United States. Some of these plans serve an entire State, others serve local communities, mainly large metropolitan areas. Table 3 lists the plans and gives for each the area served, the date on which the plan first began enrollment, and the enrollment as of January 1, 1947. ^{1/} The accompanying map shows the location of plans and the areas served.

Of the 81 plans, 26 are state-wide. One additional plan serves two States (New Hampshire and Vermont) jointly. Two other plans are state-wide, but serve a single State, North Carolina, in competition with each other. The remaining 52 plans serve local areas.

A number of plans, other than the one already cited, cross State lines. Thus the Sioux City, Iowa, plan serves the southeast corner of South Dakota. The Kansas City, Missouri, plan serves two counties in Kansas. The St. Louis, Missouri, plan serves nearby portions of Illinois. The Sacramento, California, plan serves one county in Nevada. A few other unimportant instances could be cited. With these exceptions, however, the plans confine their operations to a single State, and this pattern seems to be rather definitely established.

In terms of the areas of the United States which are served by plans, there are 28 States and the District of Columbia which are served by single plans on a state-wide basis; one State (North Carolina) is served by two competing state-wide plans; ten States (California, Illinois, Iowa, Kentucky, Missouri, New York, Ohio, Pennsylvania, Tennessee, Virginia) are served by two or more local plans which together cover the entire area of the State; three States (Georgia, Louisiana, and West Virginia) are served by local plans which cover only portions of the State; two States (Nevada and South Dakota) are served in part by plans with headquarters in other States; and four States (Arkansas, Mississippi, South Carolina, and Wyoming) are not served by any Blue Cross plan.

The above description is in terms of the declared or claimed jurisdictions of the various plans, and not in terms of the areas in which aggressive enrollment efforts are being made. A plan may, for example, be state-wide in name and intention but may in fact be conducting enrollment only in certain portions of the State.

The rule is that the plans serve mutually exclusive areas, a particular State or area being served by only one plan. The primary exception to this rule is the situation in North Carolina where two state-wide plans serve the

^{1/} Appendix A gives the address of each plan and the name of the executive director. Appendix B defines the areas served by local (non-state-wide) plans. Appendix C gives the enrollment in each plan for the years 1936 to 1947.

AREAS SERVED BY BLUE CROSS HOSPITAL SERVICE PLANS

JANUARY 1, 1947

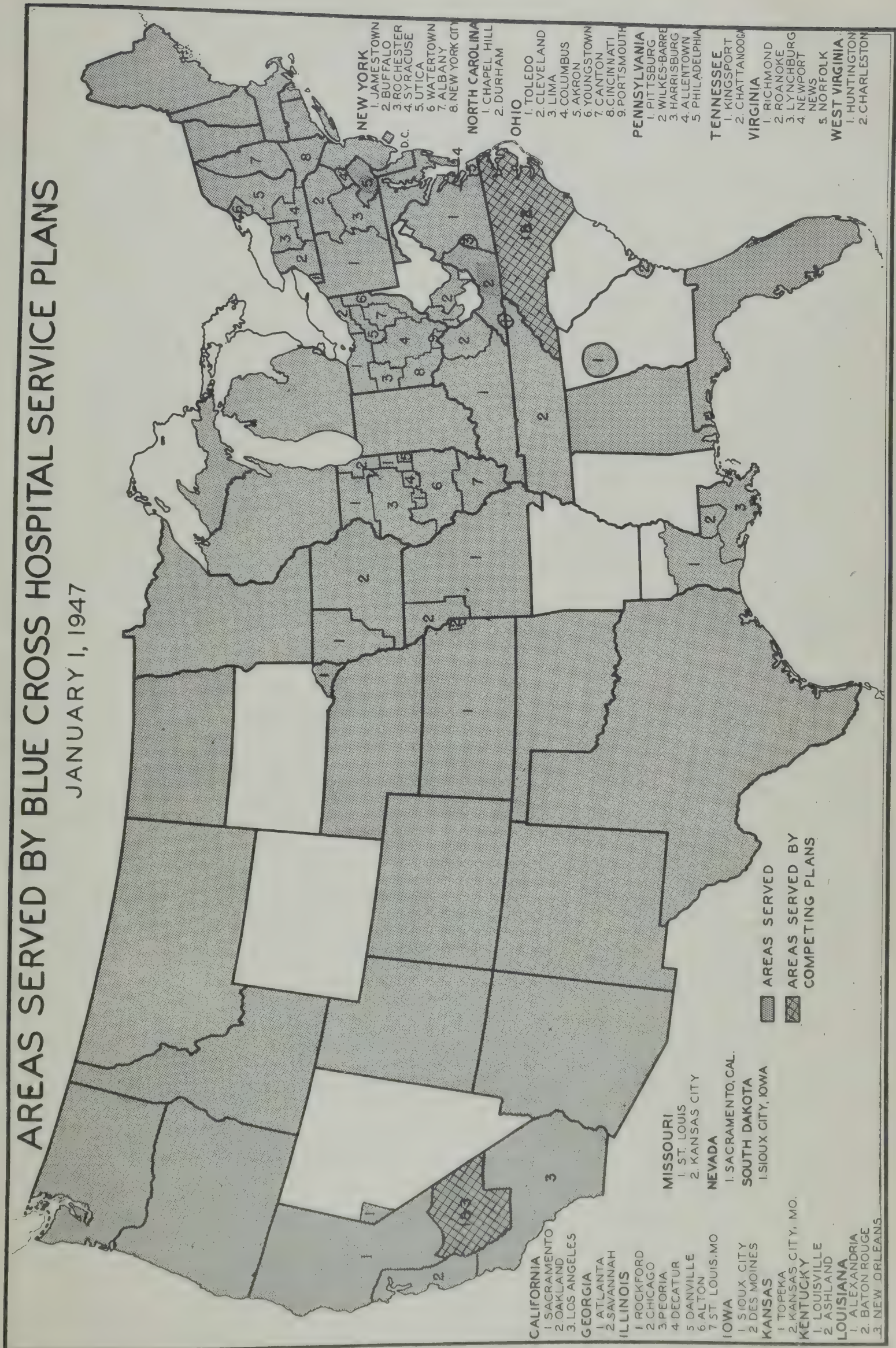


FIGURE 1

TABLE 3

BLUE CROSS PLANS, AREA SERVED, DATE OF FIRST ENROLLMENT, PRESENT ENROLLMENT. ^{a/}

* Plan has affiliated medical plan or offers medical service coverage. Data as of January 1, 1947
 # Indicates plan included in field survey. (United States only)

STATE	NAME OF PLAN AND HEADQUARTERS CITY	AREA SERVED ^{b/}	DATE OF FIRST ENROLLMENT	ENROLLMENT JAN. 1, 1947
ALABAMA	* HOSPITAL SERVICE CORP. OF ALABAMA, BIRMINGHAM	STATE-WIDE	APR. 1936	174,822
ARKANSAS	NO PLAN	-	-	-
ARIZONA	ASSOC. HOSPITAL SERVICE OF ARIZONA, PHOENIX	STATE-WIDE	OCT. 1944	35,432
CALIFORNIA	* HOSPITAL SERVICE OF SO. CALIFORNIA, LOS ANGELES * HOSPITAL SERVICE OF CALIFORNIA, OAKLAND	SOUTHERN CALIFORNIA OAKLAND - SAN FRANCISCO AND NEARBY AREAS	MAR. 1938	304,735
	* INTERCOAST HOSPITALIZATION INS. ASS., SACRAMENTO	NORTHERN CALIFORNIA AND PART OF NEVADA	JAN. 1937	196,421
	* COLORADO HOSPITAL SERVICE, DENVER	STATE-WIDE	JULY 1932	51,933
COLORADO	* CONNECTICUT HOSPITAL SERVICE, INC., NEW HAVEN	STATE-WIDE	OCT. 1936	415,757
CONNECTICUT	* GROUP HOSPITAL SERVICE, INC., WILMINGTON	STATE-WIDE	FEB. 1937	650,000
DELAWARE	* GROUP HOSPITAL SERVICE CORP., JACKSONVILLE	DISTRICT OF COLUMBIA	NOV. 1935	130,956
DISTRICT OF COLUMBIA	* FLORIDA HOSPITAL SERVICE CORP., ATLANTA	STATE-WIDE	JUNE 1934	296,300
FLORIDA	* UNITED HOSPITALS SERVICE ASS., ATLANTA	STATE-WIDE	JULY 1944	73,735
GEORGIA	* HOSPITAL SERVICE ASS. OF SAVANNAH, SAVANNAH	ATLANTA AND AREA WITHIN A 50 MILE RADIUS	JAN. 1938	49,536
	* IDAHO HOSPITAL SERVICE, BOISE	SAVANNAH AND ADJACENT COUNTIES	JUNE 1939	21,234
IDAHO	GROUP HOSPITAL SERVICE OF ILLINOIS, ALTON	STATE-WIDE	JULY 1946	25,233
ILLINOIS	BLUE CROSS PLAN FOR HOSPITAL CARE, CHICAGO ASSOCIATED HOSPITALS OF DANVILLE, DANVILLE DECATUR HOSPITAL SERVICE CORP., DECATUR CENTRAL ILLINOIS HOSP. SERVICE ASS., PEORIA ^{c/} NORTHERN ILLINOIS HOSP. SERVICE, INC., ROCKFORD	ALTON AND SOUTH CENTRAL ILLINOIS CHICAGO METROPOLITAN AREA VERMILION AND EDGAR COUNTIES DECATUR AND NEARBY COUNTIES CENTRAL ILLINOIS NORTHERN ILLINOIS AND SCATTERED AREAS	JUNE 1938	99,680
	* BLUE CROSS HOSPITAL SERVICE, INDIANAPOLIS	STATE-WIDE	JAN. 1937	1,178,584
INDIANA	* HOSPITAL SERVICE, INC. OF IOWA, DES MOINES	CENTRAL AND EASTERN IOWA	AUG. 1937	11,760
IOWA	* ASSOCIATED HOSPITALS SERVICE, INC., SIOUX CITY	WESTERN IOWA AND PART OF SOUTH DAKOTA	JAN. 1938	30,848 ^{c/}
	* KANSAS HOSPITAL SERVICE ASSN., INC., TOPEKA	KANSAS EXCEPT JOHNSON & WYANDOTTE COUNTIES	DEC. 1936	123,556 ^{c/}
KANSAS	ASHLAND HOSPITAL SERVICE, ASHLAND COMMUNITY HOSPITAL SERVICE, INC., LOUISVILLE	STATE-WIDE	MAY 1939	326,992
	* HOSPITAL SERVICE ASSN. OF ALEXANDRIA, ALEXANDRIA * HOSPITAL SERVICE ASSN. OF BATON ROUGE, BATON ROUGE * HOSPITAL SERVICE ASSN. OF NEW ORLEANS, NEW ORLEANS	CENTRAL AND WESTERN KENTUCKY CENTRAL LOUISIANA BATON ROUGE AND NEARBY PARISHES SOUTHERN LOUISIANA	OCT. 1942	224,990
KENTUCKY	ASSOCIATED HOSPITAL SERVICE OF MAINE, PORTLAND	STATE-WIDE	JAN. 1940	344,061
			MAR. 1940	61,010
LOUISIANA			JULY 1942	217,548
			APR. 1936	14,610
			AUG. 1938	182,110
			OCT. 1938	16,041
			NOV. 1938	14,101
			FEB. 1934	126,477
MAINE			NOV. 1938	190,000

MARYLAND	* ASSOCIATED HOSP. SERVICE OF BALTIMORE, BALTIMORE	STATE-WIDE	NOV. 1937	440,575
MASSACHUSETTS	* MASSACHUSETTS HOSPITAL SERVICE, INC., BOSTON	STATE-WIDE	OCT. 1937	1,991,000
MICHIGAN	* MICHIGAN HOSPITAL SERVICE, DETROIT	STATE-WIDE	MAR. 1939	1,167,365
MINNESOTA	* MINNESOTA HOSPITAL SERVICE ASSN., ST. PAUL	STATE-WIDE	JULY 1933	757,489
MISSISSIPPI	NO PLAN	-	-	-
MISSOURI	* GROUP HOSPITAL SERVICE, INC., KANSAS CITY	NORTHWESTERN MISSOURI AND JOHNSON AND WYANDOTTE COUNTIES IN KANSAS	JULY 1938	185,000
MONTANA	* GROUP HOSPITAL SERVICE, INC., ST. LOUIS	REMAINDER OF MISSOURI AND PART OF SOUTHERN ILLINOIS	APR. 1936	755,153
MONTANA	* HOSPITAL SERVICE ASSN. OF MONTANA, HELENA	STATE-WIDE	FEB. 1941	55,243
NEBRASKA	* ASSOCIATED HOSPITAL SERVICE OF NEBRASKA, OMAHA	STATE-WIDE	FEB. 1939	80,907
NEW HAMPSHIRE	* NEW HAMPSHIRE VERMONT HOSPITALIZATION SERV., CONCORD	NEW HAMPSHIRE AND VERMONT	DEC. 1942	197,249
NEW JERSEY	* HOSPITAL SERVICE PLAN OF NEW JERSEY, NEWARK	STATE-WIDE	JAN. 1933	929,915
NEW MEXICO	* HOSPITAL SERVICE, INC., ALBUQUERQUE	STATE-WIDE	JULY 1940	8,683
NEW YORK	* ASSOC. HOSPITAL SERV. OF CAPITAL DIST., ALBANY	ALBANY AND NORTHEASTERN NEW YORK	SEP. 1936	181,984
	* HOSPITAL SERVICE CORP. OF WESTERN N.Y., BUFFALO	BUFFALO AND ADJACENT COUNTIES	JAN. 1937	421,002
	* CHAUTAUQUA REGION HOSPITAL SERV. CORP., JAMESTOWN	CHAUTAUQUA COUNTY	FEB. 1937	27,767
	* ASSOCIATED HOSPITAL SERVICE OF N.Y., N.Y. CITY	NEW YORK CITY & SOUTHEASTERN NEW YORK	MAY 1935	2,779,811
	* ROCHESTER HOSPITAL SERVICE CORP., ROCHESTER	ROCHESTER AND ADJACENT COUNTIES	JUNE 1935	313,364
	* GROUP HOSPITAL SERVICE, INC., SYRACUSE	SYRACUSE AND ADJACENT COUNTIES	JAN. 1936	231,021
	* HOSPITAL PLAN, INC., UTICA	UTICA AND NORTHCENTRAL NEW YORK	FEB. 1937	136,049
	* HOSPITAL SERVICE CORP. OF JEFFERSON COUNTY, WATERTOWN	JEFFERSON COUNTY	JULY 1937	13,607
NEVADA	NO PLAN - RENO AREA IS SERVED BY SACRAMENTO PLAN	-	-	-
NORTH CAROLINA	* HOSPITAL SAVING ASSN. OF NORTH CAROLINA, CHAPEL HILL	STATE-WIDE	DEC. 1935	313,000
	* HOSPITAL CARE ASSN. INC., DURHAM	STATE-WIDE	AUG. 1933	144,544
NORTH DAKOTA	* NORTH DAKOTA HOSPITAL SERVICE ASSN., FARGO	STATE-WIDE	APR. 1940	52,955
OHIO	* AKRON HOSPITAL SERVICE, AKRON	AKRON AND ADJACENT COUNTIES	JAN. 1937	148,423
	* HOSPITAL SERVICE INC. OF STARK COUNTY, CANTON	CANTON AND ADJACENT COUNTIES	OCT. 1938	104,178
	* HOSPITAL CARE CORP., CINCINNATI	CINCINNATI AND SOUTHEASTERN OHIO	SEP. 1939	639,920
	* CLEVELAND HOSPITAL SERVICE ASSN., CLEVELAND	CLEVELAND AND ADJACENT COUNTIES	SEP. 1934	970,000
	* CENTRAL HOSPITAL SERVICE, COLUMBUS	COLUMBUS AND SOUTHCENTRAL OHIO	DEC. 1938	194,400
	* HOSPITAL SERVICE INC., LIMA	LIMA AND ADJACENT COUNTIES	JUNE 1940	49,862
	* PORTSMOUTH HOSPITAL SERVICE ASSN. PORTSMOUTH	SCIOTO COUNTY	JAN. 1939	22,768
	* HOSPITAL SERVICE ASSN. OF TOLEDO, TOLEDO	TOLEDO AND NORTHWESTERN OHIO	APR. 1938	262,797
	* ASSOCIATED HOSP. SERVICE, INC., YOUNGSTOWN	YOUNGSTOWN AND EASTERN BORDER COUNTIES	MAR. 1938	175,076
OKLAHOMA	* GROUP HOSPITAL SERVICE, TULSA	STATE-WIDE	MAY 1940	170,597
OREGON	* NORTHWEST HOSPITAL SERVICE PLAN, PORTLAND	STATE-WIDE	JUNE 1942	64,019
PENNSYLVANIA	* HOSPITAL SERVICE PLAN OF LEHIGH VALLEY, ALLENTOWN	LEHIGH & NORTHAMPTON COUNTIES	OCT. 1935	139,214
	* CAPITAL HOSPITAL SERVICE, INC., HARRISBURG	HARRISBURG AND SOUTHCENTRAL PENNSYLVANIA	MAR. 1938	291,585
	* ASSOCIATED HOSPITAL SERVICE OF PHILADELPHIA, PHILADELPHIA	PHILADELPHIA METROPOLITAN AREA IN PENNSYLVANIA	NOV. 1938	1,062,207
	* HOSPITAL SERVICE ASSN. OF PITTSBURGH, PITTSBURGH	WESTERN PENNSYLVANIA	JAN. 1938	1,047,691

TABLE 3

BLUE CROSS PLANS, AREA SERVED, DATE OF FIRST ENROLLMENT, PRESENT ENROLLMENT. a/

* Plan has affiliated medical plan or offers medical service coverage. Data as of January 1, 1947
 # Indicates plan included in field survey. (United States only)

STATE	NAME OF PLAN AND HEADQUARTERS CITY	AREA SERVED b/	DATE OF FIRST ENROLLMENT	ENROLLMENT JAN. 1, 1947
PENNSYLVANIA	* HOSPITAL SERVICE ASSN. OF NORTHEASTERN PA., WILKES-BARRE	NORTHEASTERN PENNSYLVANIA	DEC. 1938	195,371
RHODE ISLAND	* HOSPITAL SERVICE CORP. OF RHODE ISLAND, PROVIDENCE	STATE-WIDE	SEP. 1939	463,362
SOUTH CAROLINA	NO PLAN	-	-	-
SOUTH DAKOTA	NO PLAN - SERVED TO SOME EXTENT BY THE SIOUX CITY PLAN	-	-	-
TENNESSEE	TENNESSEE HOSPITAL SERVICE ASSN., CHATTANOOGA COMMUNITY HOSPITAL SERVICE, KINGSFORT	STATE EXCEPT KINGSFORT AREA KINGSFORT AND AREA WITHIN 25 MILE RADIUS	OCT. 1945 AUG. 1935	102,052 31,665
TEXAS	* GROUP HOSPITAL SERVICE, DALLAS	STATE-WIDE	JUNE 1939	215,660
UTAH	* INTERMOUNTAIN HOSPITAL SERVICE, SALT LAKE CITY	STATE-WIDE	JAN. 1945	75,794
VERMONT	SERVED BY NEW HAMPSHIRE-VERMONT PLAN	LYNCHBURG AND ADJOINING COUNTIES	SEP. 1938	7,913
VIRGINIA	* PIEDMONT HOSPITAL SERVICE ASSN., LYNCHBURG * VIRGINIA PENINSULA HOSPITAL SERVICE ASSN., NEWPORT NEWS	NEWPORT NEWS AND NEARBY COUNTIES NORFOLK CITY AND NORFOLK AND PRINCESS ANNE COUNTIES	MAY 1938	18,334
	* TIDEWATER HOSPITAL SERVICE ASSN., NORFOLK	CENTRAL AND NORTHERN VIRGINIA	SEP. 1935	37,142
	* VIRGINIA HOSPITAL SERVICE ASSN., RICHMOND	ROANOKE AND ADJACENT AREAS	OCT. 1935	155,424
	* HOSPITAL SERVICE ASSN. OF ROANOKE, ROANOKE	STATE-WIDE	OCT. 1939	54,429
WASHINGTON	* WASHINGTON HOSPITAL SERVICE, SEATTLE	STATE-WIDE	JUNE 1942	93,817
WEST VIRGINIA	* HOSPITAL SERVICE, INC., CHARLESTON * HUNTINGTON HOSPITAL SERVICE, INC., HUNTINGTON	CHARLESTON AND CENTRAL WEST VIRGINIA HUNTINGTON AND WESTERN WEST VIRGINIA	JAN. 1933 JAN. 1939	57,970 37,068
WISCONSIN	* ASSOCIATED HOSPITAL SERVICE, INC., MILWAUKEE	STATE-WIDE	JAN. 1940	589,200
WYOMING	NO PLAN	-	-	-
PUERTO RICO	PUERTO RICO HOSPITAL SERVICE ASSOCIATION	ISLAND-WIDE	JAN. 1944	33,090

NOTES:

- a/ Data from Blue Cross Commission.
 b/ See Appendix B for precise description of areas served by local (non-state-wide) plans.
 c/ Merged with the Chicago plan, January 21, 1947.

State in competition with each other. A few other exceptions exist. Here local plans in expanding into new territory are serving certain counties claimed by other plans to be within their territory, or the jurisdictional boundaries between two local plans expanding toward each other have not as yet been defined. For example, in California, the plan serving the southern part of the State has recently begun to conduct enrollment in counties to the north which have been thinly served by another plan. In Illinois an aggressive plan has invaded territory claimed by other plans as being within their jurisdiction. In two or three other States a particular county or two are served by two plans. In general such situations are probably of a temporary character only.

New plans are constantly being started. Thus in 1944, 1945 and 1946 plans were started in Arizona, Florida, Idaho, Indiana, Tennessee, and Utah; and previously existing plans in New Mexico, Charleston (West Virginia), and Alexandria (Louisiana) were reorganized and approved. The Blue Cross Commission reports developments under way in the States now without plans which make it likely that in another year or two most or all of these States will have state-wide plans.

As indicated in the previous chapter the plans first established were designed to serve a local community. In recent years certain disadvantages attending the existence of multiple plans within a State have been manifest, and in the last four or five years the Blue Cross Commission has discouraged the establishment of plans except on a state-wide basis. In one State, Connecticut, two former plans were amalgamated in 1943 to form a state-wide plan. In a number of States proposals have been made that the various local plans merge or federate into a state-wide plan. Many Blue Cross leaders believe that there should be no more than 49 plans in the continental United States -- one for each State and the District of Columbia.

SIZE OF PLANS

The plans vary greatly in size. Some are large organizations with over a million or a half million participants; others, many of them but recently started, have only a few thousand or tens of thousands of subscribers.

The number of plans of different size groups and their aggregate enrollment, as of January 1, 1947, was as follows:

SIZE OF PLAN (PARTICIPANTS)	NUMBER OF PLANS	TOTAL NUMBER OF PARTICIPANTS	PERCENT OF TOTAL PARTICIPANTS IN ALL PLANS
500,000 OR MORE	13	14,518,335	59.9
200,000 - 500,000	16	5,082,749	21.0
100,000 - 200,000	21	3,353,903	13.8
LESS THAN 100,000	31	1,295,096	5.3
ALL PLANS	81	24,250,083	100.0

It is evident that a small number of the larger plans have a large share of the total participants in all plans. Thus the 13 plans with 500,000 or more participants had 59.9 percent of the total participants in all plans.

On the other hand, the 31 plans with less than 100,000 participants each, together had only 5.3 percent of the total participants.

POPULATION SERVED

The plans had a total enrollment as of January 1, 1947 of 24,250,083. As indicated by Table 4 and Figure 2, there is a fairly high degree of concentration of these members in a few States. The six States of New York, Ohio, Pennsylvania, Massachusetts, Illinois, and Michigan, which have 36 percent of the total population of the country, have 59 percent of all Blue Cross members. The Northeastern and North Central States, which have 57 percent of the total population of the country have 83 percent of the total Blue Cross enrollment; the South and the West, with 43 percent of the country's population, have only 17 percent of all Blue Cross members.

As of January 1, 1947 the plans had enrolled 19.0 percent of the total population of the country. ^{2/} In a few States a substantial portion of the population has been enrolled. The Rhode Island plan has enrolled two-thirds of the population of its State. In Massachusetts and Delaware almost half of the population has been enrolled. In Colorado, Ohio, Connecticut, the District of Columbia, New York and Minnesota between 30 and 40 percent of the population are Blue Cross members. In another ten States (Pennsylvania, Missouri, New Hampshire and Vermont (considered as a unit), Maine, Illinois, New Jersey, Maryland, Michigan and Wisconsin) between 20 and 30 percent of the population are enrolled. By contrast, there are four States in which none of the population is enrolled, and another eight States in which less than five percent of the population are plan members. ^{3/}

In a number of localities, a high percentage of the population has been enrolled. The Cleveland plan has enrolled 66 percent of the population of its area. This plan has probably enrolled over 70 percent of the population of the city of Cleveland. The Rochester plan reports that it has enrolled over 75 percent of the population of the city of Rochester. The Rockford (Illinois) plan has enrolled over 56 percent of the population of Winnebago County and close to 75 percent of the population of the city of Rockford.

GROWTH TRENDS

In general the plans have been enrolling an increasing percentage of the population each year. Thus in 1942 the plans enrolled 1.42 percent of the total population; in 1943, 1.92 percent; in 1944, 2.43 percent; 1945, 2.46 percent; ^{4/} and in 1946, 4.21 percent. (See Figure 4).

^{2/} Of the estimated civilian population as of July 1, 1945 the most recent date for which estimates of the population by States are available. Of the total population of approximately 140,000,000, 17.3 percent have been enrolled.

^{3/} See Table 5. Both South Dakota and Nevada have less than five percent of their populations enrolled.

^{4/} Enrollment gains during the last half of 1945 were cut down owing to high labor turnover due to reconversion.

ENROLLMENT IN BLUE CROSS HOSPITAL SERVICE PLANS, JANUARY 1, 1947

EACH ● REPRESENTS 100,000 PARTICIPANTS

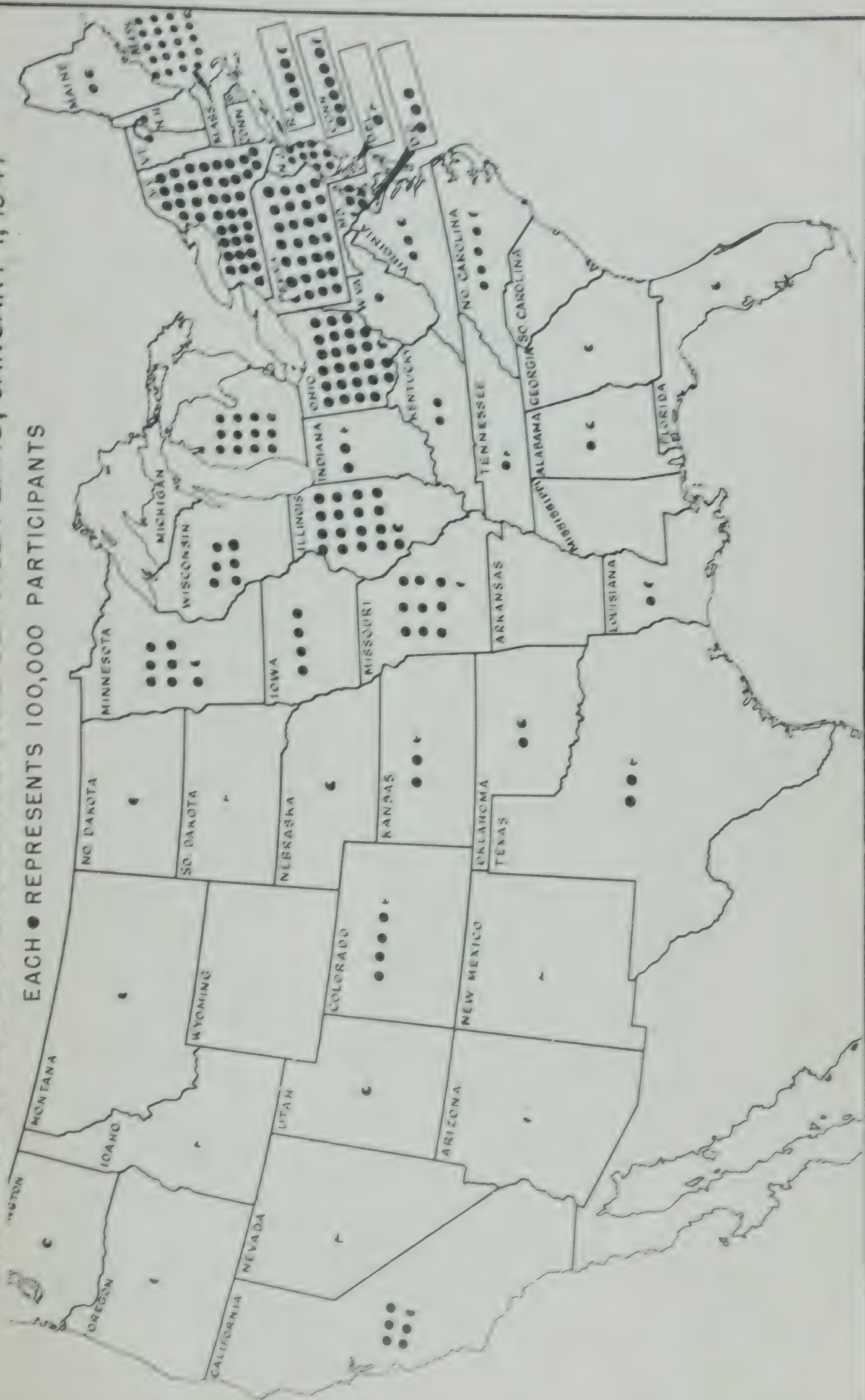


FIGURE 2

TABLE 4

Enrollment by State on January 1, 1947, Estimated Civilian Population as of July 1945, Percent of Total Population Enrolled, and Percent of Population Enrolled During 1946 and 1945. a/

STATE	NO. OF PLANS	ENROLLMENT JAN. 1, 1947	ESTIMATED CIVILIAN POPULATION JULY 1945 <u>b/</u>	PERCENT OF POPULATION ENROLLED JAN. 1, 1947	PERCENT OF POPULATION ENROLLED DURING 1946	PERCENT OF POPULATION ENROLLED DURING 1945
Rhode Island	1	463,362	698,903	66.30	17.47	13.52
Massachusetts	1	1,991,000	4,086,197	48.73	13.69	11.41
Delaware	1	130,956	277,455	47.20	7.35	4.90
Colorado	1	415,757	1,060,239	39.21	9.50	4.10
Ohio	9	2,567,424	6,823,137	37.63	6.39	1.01
Connecticut	1	650,000	1,768,602	36.75	7.06	4.23
District of Columbia	1	296,300	836,900	35.40	7.32	3.30
New York	8	4,104,605	12,343,450	33.25	6.54	3.87
Minnesota	1	757,489	2,484,993	30.48	4.80	1.28
Pennsylvania	5	2,736,068	9,142,797	29.93	7.01	3.60
Missouri	2	940,153	3,481,949	27.00	6.11	4.15
New Hampshire-Vermont	1	197,249	756,141	26.09	9.50	6.51
Maine	1	190,000	772,621	24.59	6.47	4.31
Illinois	6	1,771,420	7,548,109	23.47	6.17	2.49
New Jersey	1	929,915	4,104,176	22.66	3.25	3.56
Maryland	1	440,575	2,017,971	21.83	5.34	2.73
Michigan	1	1,167,365	5,435,092	21.48	-1.48	.02
Wisconsin	1	589,200	2,934,044	20.08	5.74	4.79
Iowa and South Dakota	2	405,071	2,762,810	14.66	4.35	2.40
North Carolina	2	457,544	3,333,999	13.72	2.45	1.12
Kansas	1	217,548	1,656,588	13.13	3.95	4.72
Utah	1	75,794	591,910	12.80	8.21	4.66
Montana	1	55,243	452,519	12.21	7.63	1.39
North Dakota	1	52,955	519,709	10.19	2.11	.89
Virginia	5	273,242	2,810,278	9.72	2.04	1.73
Oklahoma	1	170,597	1,941,499	8.79	2.49	1.83
Kentucky	2	196,720	2,520,537	7.80	2.14	1.58
Nebraska	1	80,907	1,155,744	7.00	2.01	1.49
California and Nevada	3	553,089	8,255,794	6.70	3.11	.77
Louisiana	3	156,619	2,343,406	6.68	1.09	-.32
Indiana	1	224,990	3,387,463	6.64	2.49	3.91
Alabama	1	174,822	2,728,120	6.41	1.24	.20
Arizona	1	35,432	589,221	6.01	2.77	3.07
West Virginia	2	95,038	1,716,944	5.53	.88	2.82
Idaho	1	25,233	459,938	5.49	5.49	-
Oregon	1	64,019	1,193,702	5.36	1.16	.71
Washington	1	93,817	1,953,725	4.80	.32	1.31
Tennessee	2	133,717	2,832,480	4.72	3.04	.71
Florida	1	73,735	2,059,505	3.58	2.22	1.17
Texas	1	215,660	6,338,309	3.40	1.20	.45
Georgia	2	70,770	3,002,896	2.36	.47	.20
New Mexico	1	8,683	490,302	1.77	1.30	.47
Total U.S. Served by Blue Cross plans	81	24,250,083	121,670,174	19.93	4.41	2.58
States not served by Blue Cross plans:						
Arkansas	-	-	1,716,914	-	-	-
Mississippi	-	-	1,990,073	-	-	-
South Carolina	-	-	1,797,583	-	-	-
Wyoming	-	-	234,553	-	-	-
Total United States	81	24,250,083	127,409,297	19.03	4.21	2.46
Puerto Rico	1	33,090	1,869,255 <u>c/</u>	1.77	.83	-.34

a/ Enrollment data from Blue Cross Commission.

b/ Latest date for which estimates of population by State are available.

c/ 1941.

PERCENTAGE OF POPULATION ENROLLED IN BLUE CROSS HOSPITAL SERVICE PLANS

JANUARY 1, 1947

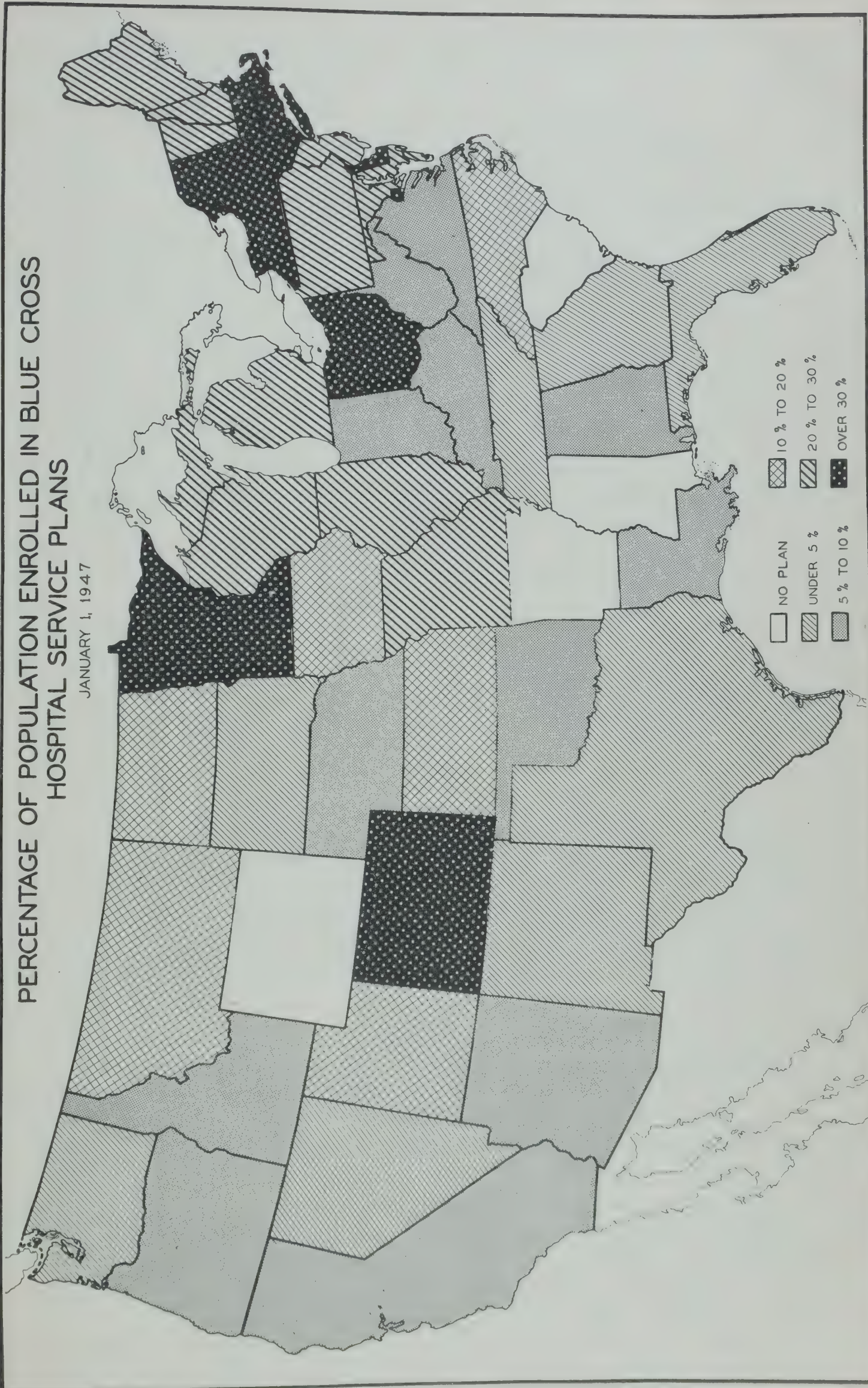


FIGURE 3

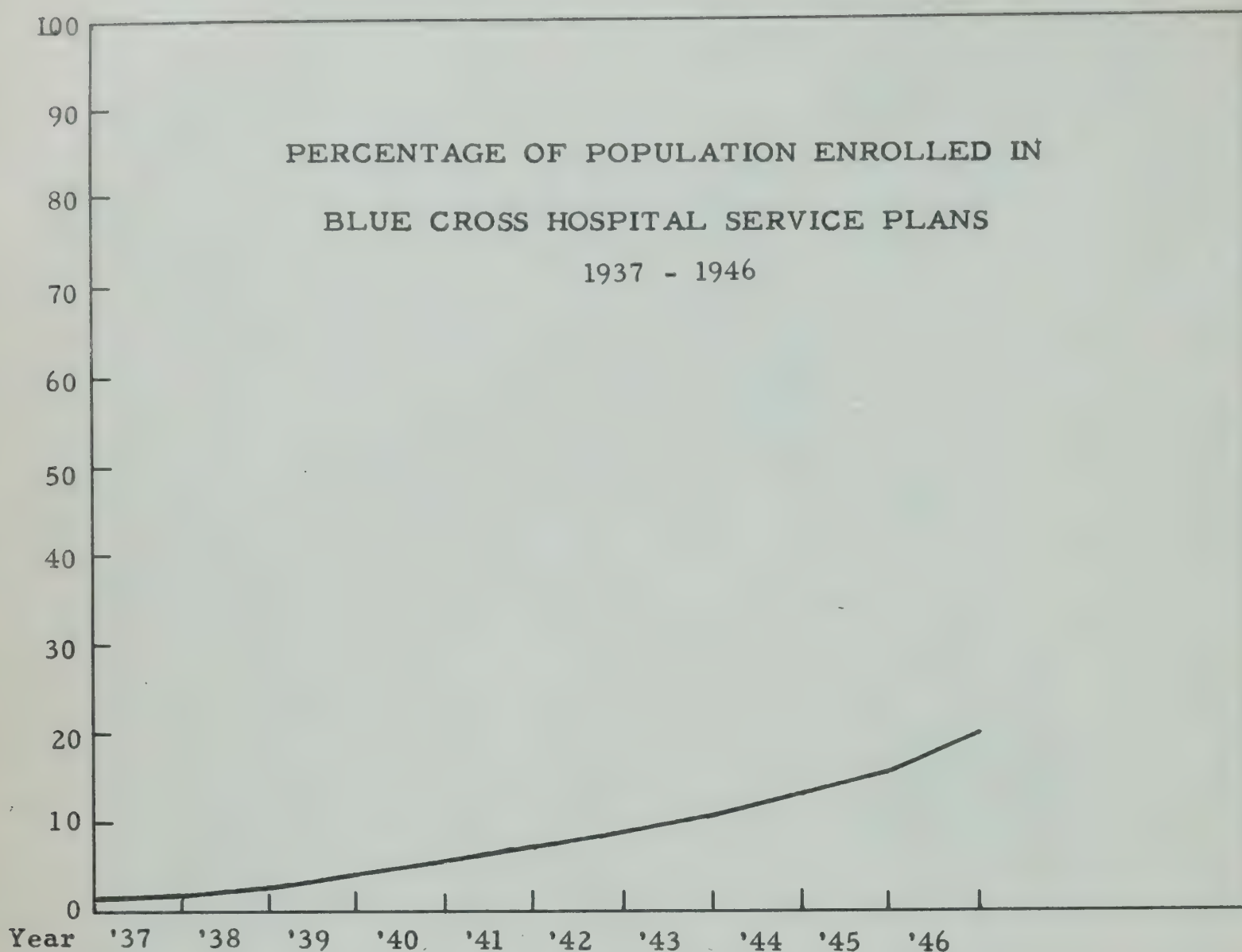


Fig. 4

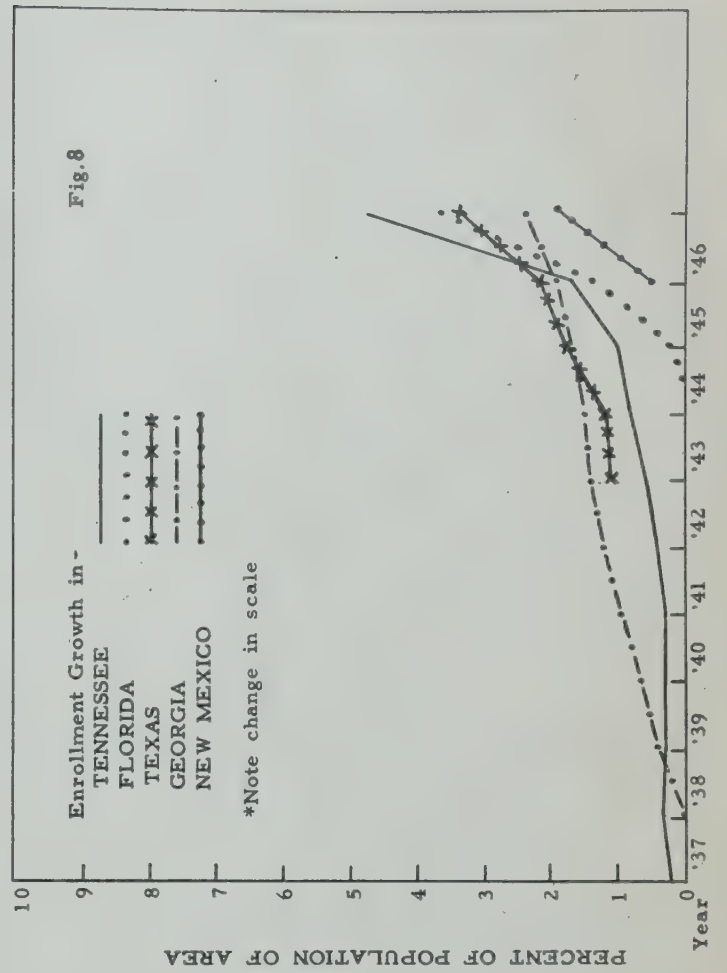
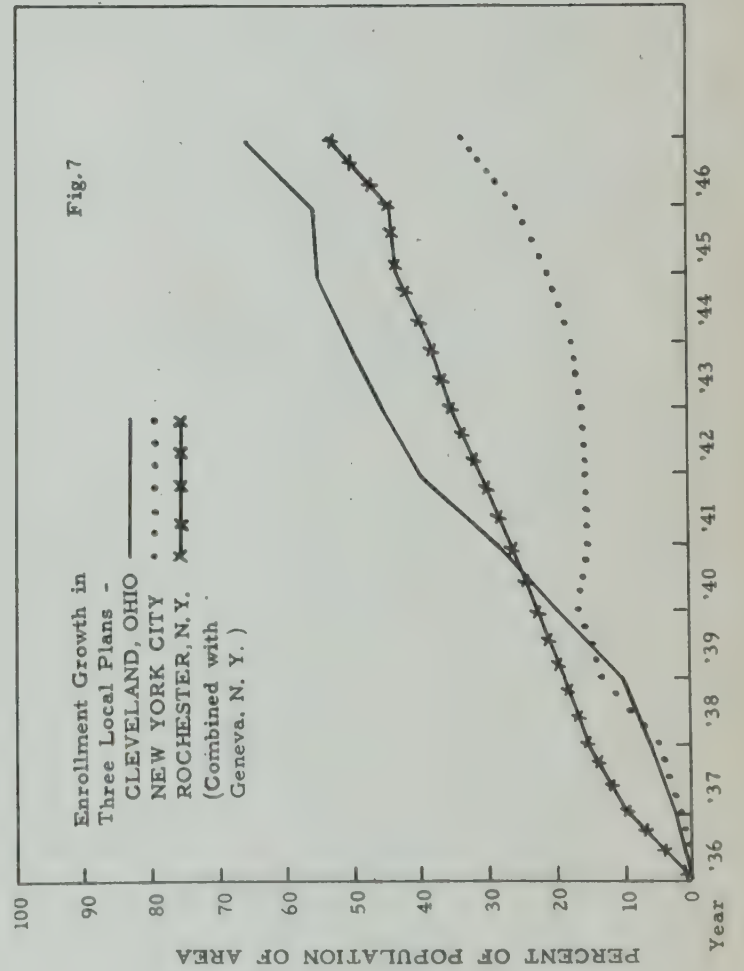
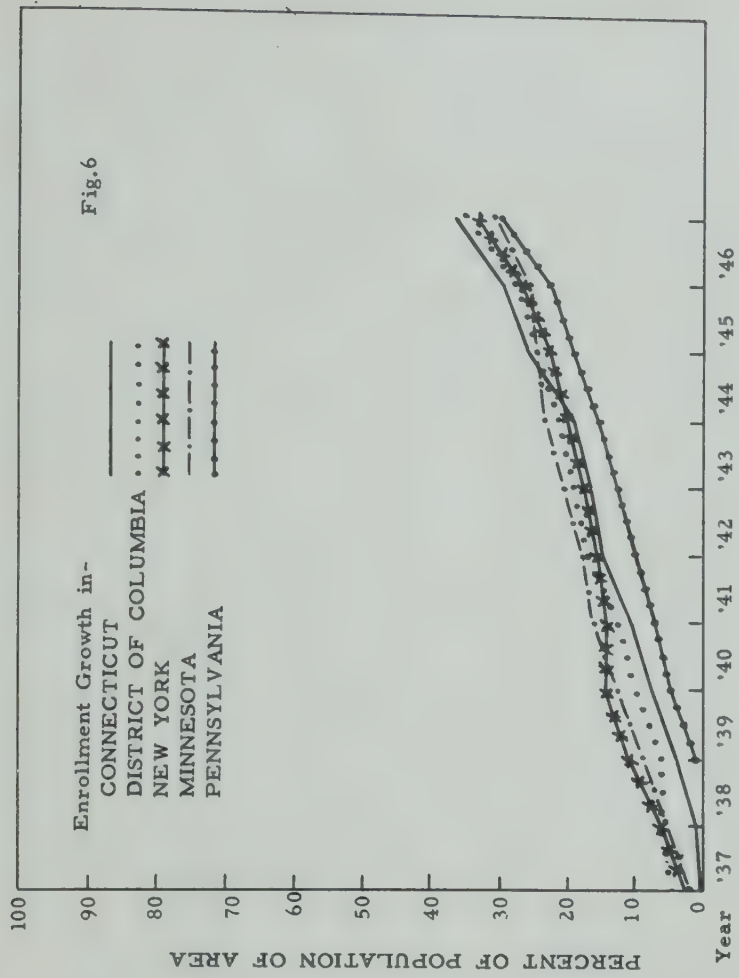
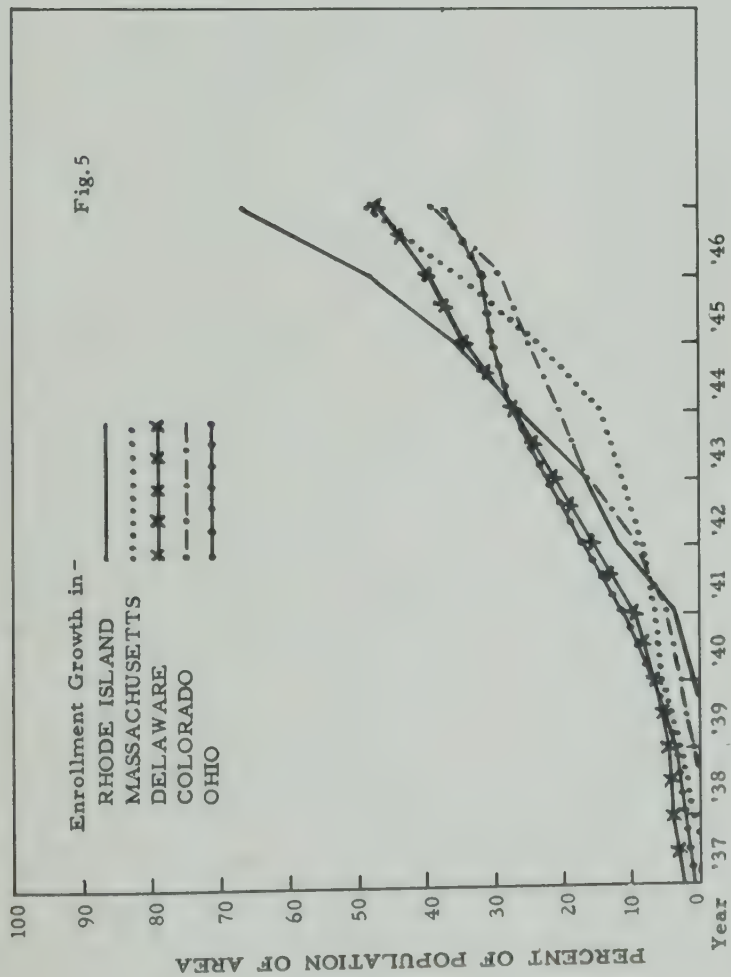
In a few States the plans have been enrolling the population at a rapid rate. Thus during 1945 and 1946 the Rhode Island plan enrolled 31.0 percent of the population of that State; in the same period the Massachusetts plan enrolled 25.1 percent of the population of that State. In 1946 the New Hampshire-Vermont plan enrolled 9.5 percent of the population of these two States. On the other hand there were 9 States, exclusive of those without plans, in which less than 2 percent of the State's population were enrolled during 1946.

Figures 5 and 6 show the growth in percentage of the population enrolled in the 10 States which on January 1, 1947 had the highest percentage of the population enrolled. Figure 7 shows for three local plans -- New York City, Cleveland and Rochester -- the growth in the percentage of the population of the area enrolled. Figure 8 shows the enrollment growth in the five States which have the least percentage of the population enrolled.

Some plans, as these graphs illustrate, have grown at quite steady rates, that is, in each year of their life, except perhaps the first or second, they have enrolled about the same percentage of the population of their areas. Others have grown at uneven rates. Frequently a plan grows quite rapidly for a period. Then follows a year or so in which growth is slow, during which the plan consolidates its gains, overcomes some difficulty, revises administrative procedures to handle the expanded enrollment, develops new enrollment techniques to tap new segments of the population, etc. Then growth will again

BLUE CROSS ENROLLMENT TRENDS IN SPECIFIED STATES AND LOCALITIES

1937 - 1946



proceed rapidly. An example is the New York City plan which grew rapidly during 1938, encountered difficulties in 1939 as a result of which it was forced to cancel out large numbers of subscribers enrolled on an individual basis, and which did not begin again to grow rapidly until 1944. Another outstanding example (not shown in the graphs) is the Michigan plan. This increased its enrollment from 330,000 on January 1, 1941 to 817,000 a year later. The following year it grew hardly at all -- it was raising its subscription rates (which meant that the time of the enrollment representatives was absorbed in changing existing groups to the new basis, rather than in selling new groups) and revising internal administration. Then during 1943 and 1944 growth was again rapid. During 1945 and 1946 the plan had administrative and financial problems and grew not at all.

Some plans have grown at relatively moderate rates during the first few years of their existence, and then have rapidly accelerated the pace of enrollment. An example is the Massachusetts plan which from its establishment in 1937 had enrolled 460,000 persons (11.3 percent of the population) by January 1, 1943. Then enrollment began rapidly to increase, and by January 1, 1947 had reached 1,990,000 (48.7 percent of the population). On the other hand, some plans have grown only slowly throughout their entire history. Thus the two plans in Georgia, established in 1938 and 1939 respectively, have thus far managed to enroll only 70,000 people.

The growth history of the plans which have achieved substantial enrollment suggests that the first five or ten percent of the population is the hardest to enroll; thereafter enrollment is easier, or at any rate proceeds more rapidly. It has sometimes been suggested that the plans as they achieve substantial enrollment in their area would reach a saturation point -- a point at which they would have enrolled all those in their territory who could be reached or who could afford the subscription costs. Thus far the growth trends of the plans show no evidence of any such point having been reached.

ENVIRONMENTAL FACTORS AFFECTING DEVELOPMENT AND GROWTH OF THE PLANS

By and large the plans have made the greatest headway in those areas characterized by strong, well organized voluntary hospitals, relatively adequate hospital facilities, a high degree of urbanization and industrialization, and relatively high per capita income. By contrast the movement has made least progress in areas where hospitals are weak and are largely proprietary or governmental, where hospital facilities are inadequate, where the population is largely rural and agricultural, and where per capita incomes are low. Most of these factors go together.

Generally the plans have been started by the voluntary hospitals of the area and it is these hospitals which have been identified with and have supported the plans. Consequently the plans have been started earliest and with most success in communities with strong voluntary hospitals, which are organized into a council or association, and are used to working together, and which feel a high degree of responsibility towards the community as a whole.

The movement has made relatively little headway thus far in the Pacific coast States. Here all the conditions except one are seemingly favorable. The exception is that the voluntary hospitals of these States are not strong or more accurately they are not strongly voluntary. Many of the voluntary

TABLE 5

Ranking of States According to Per Capita Income, Percent of Population Enrolled in Blue Cross Plans, and Percent of Population Living in Urban Areas

STATE	1942-44 PER CAPITA INCOME	RANKING OF STATE AC- CORDING TO PER CAPITA INCOME	PER CENT OF POP. ENROLLED IN BLUE CROSS PLANS JAN. 1, 1947	RANKING OF STATE ACCORD- ING TO POP. ENROLLED	PERCENT OF POP. LIVING IN URBAN AREAS (1940)	RANKING OF STATE ACCORD- ING TO PER- CENT OF URBAN POP.
	\$		%			
CONNECTICUT	1,431	1	36.75	6	67.8	8
NEVADA	1,372	2	3.51 a/	41	39.3	29
CALIFORNIA	1,366	3	6.75	30	71.0	7
NEW YORK	1,343	4	33.25	8	82.8	4
WASHINGTON	1,336	5	4.80	38	53.1	18
DELAWARE	1,287	6	47.20	3	52.3	20
NEW JERSEY	1,261	7	22.66	16	81.6	5
DISTRICT OF COLUMBIA	1,254	8	35.40	7	100.0	1
OREGON	1,204	9	5.36	37	48.8	23
RHODE ISLAND	1,198	10	66.30	1	91.6	2
MICHIGAN	1,183	11	21.48	18	65.7	11
MASSACHUSETTS	1,177	12	48.73	2	89.4	3
ILLINOIS	1,175	13	23.47	15	73.6	6
MARYLAND	1,169	14	21.83	17	59.3	12
OHIO	1,167	15	37.63	5	66.8	9
PENNSYLVANIA	1,048	16	29.93	10	66.5	10
INDIANA	1,040	17	6.64	32	55.1	16
MONTANA	1,008	18	12.21	24	37.8	31
UTAH	972	19	12.80	23	55.5	14
MAINE	968	20	24.59	14	40.5	28
WISCONSIN	966	21	20.08	19	53.5	17
KANSAS	961	22	13.13	22	41.9	26
IOWA	936	23	17.97	20	42.7	25
COLORADO	935	24	39.21	4	52.6	19
WYOMING	934	25	no plan	no plan	37.3	33
IDAHO	930	26	5.49	36	33.7	39
NEBRASKA	920	27	7.00	29	39.1	30
MISSOURI	885	28	27.00	11	51.8	21
MINNESOTA	876	29	30.48	9	49.8	22
NORTH DAKOTA	872	30	10.19	25	20.6	48
VERMONT	863	31	26.09 b/	13	34.3	38
ARIZONA	833	32	6.01	34	34.8	36
FLORIDA	828	33	3.58	40	55.1	15
SOUTH DAKOTA	817	34	.59 a/	45	24.6	45
VIRGINIA	814	35	9.72	26	35.3	34
NEW HAMPSHIRE	804	36	26.09 b/	12	57.6	13
TEXAS	791	37	3.40	42	45.4	24
OKLAHOMA	720	38	8.79	27	37.6	32
W. VIRGINIA	692	39	5.53	35	28.1	43
LOUISIANA	678	40	6.68	31	41.5	27
NEW MEXICO	660	41	1.77	44	33.2	40
TENNESSEE	645	42	4.72	39	35.2	35
GEORGIA	624	43	2.36	43	34.4	37
NORTH CAROLINA	606	44	13.72	21	27.3	44
KENTUCKY	589	45	7.80	28	29.8	42
ALABAMA	579	46	6.41	33	30.2	41
SOUTH CAROLINA	560	47	no plan	no plan	24.5	46
ARKANSAS	522	48	no plan	no plan	22.2	47
MISSISSIPPI	468	49	no plan	no plan	19.8	49
UNITED STATES	\$1,005		19.03		56.5	

a/ Approximate

b/ Data not available on division of enrollment between Vermont and New Hampshire. Percentage for combined enrollment, 26.09, used for both States.

hospitals of these States were formerly proprietary and only changed to a non-profit status within the last decade or so. They provide virtually no free care and receive no aid from community chests or the public generally. They stand on their own financial legs. To provide care to those unable to pay, the city and county governments have established large, well maintained governmental hospitals. The voluntary hospitals of these States have been slow in starting or giving solid support to hospital plans and as a result the plans have as yet made relatively little headway.

The presence or absence of hospital facilities is a decisive factor. Obviously plans will not be started in communities without good hospital facilities. Nor can hospital protection be sold to a population which has no hospitals to go to, and which is not hospital minded.

The presence of industry and commerce is a favorable factor. People in employed groups can be easily reached and enrolled. The plans find it far more difficult to reach farm and rural families.

Income plays an important role, partly directly partly indirectly. The greater their income the more able people are to pay the subscription costs. Also communities characterized by high income levels generally have good hospital facilities and people who are hospital minded and health conscious. The conditions favorable to growth of the plans have been present in greatest degree in the northcentral and northeastern States and it is here that the plans have had their largest growth.

Table 5 compares the ranking of the States according to per capita income, percent of the population enrolled, and percent of the population living in urban areas. It will be apparent that in general the wealthier and more urban States have the highest percentage of their population enrolled. However there are significant exceptions to this general relationship. For example California ranks third in per capita income but has only a small proportion of its population enrolled. Colorado which is below the average in both per capita income and degree of urbanization stands fourth in percent of the population enrolled. Minnesota stands in 29th place as regards income and in 22nd place as regards percent of population living in urban areas, but stands in ninth place with respect to percent of population enrolled. New Hampshire and Vermont, considered as a unit, rank 12th among the States in enrollment but have lower per capita incomes and less of their population residing in urban areas than the country as a whole. Thus in certain States able plan leadership, aggressive enrollment efforts and good support from the hospitals have resulted in enrollment far greater than that achieved in other States with higher per capita income and a higher degree of urbanization.

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NOTE ON RECENT CHANGES

Between January 1st and June 1, 1947 the following events have taken place: Plans have been approved and have begun enrollment in Wyoming and South Carolina. Both of these are on a state-wide basis. A plan with headquarters in Memphis, Tennessee, has been approved and has begun enrollment. This will serve Memphis and surrounding territory. The Danville and Peoria plans in Illinois have been merged with the Chicago plan. The Ashland plan in Kentucky has been merged with the Huntington, West Virginia, plan.

As of April 1, 1947, the plans reported a total enrollment for the United States of 25,147,386, this being 19.74 percent of the estimated civilian population as of July 1945.

★ ★ ★ ★

CHAPTER 4

SUBSCRIPTION RATES AND BENEFITS*

Blue Cross plans operate through contracts with subscribers and hospitals. The plans contract with subscribers to furnish certain hospital services in return for certain subscription charges paid periodically. The plans provide the specified services to subscribers through their "member" hospitals, i. e., hospitals of the area which contract to furnish the stipulated hospital services to subscribers in return for certain payments by the plans.

The provisions of the subscriber contracts, as reported by the plans to the Blue Cross Commission as of December 1, 1946, are shown in detail in Appendix D, Tables 1 to 9. Changes are constantly occurring in the contract provisions of the various plans so that any description of these provisions rapidly becomes obsolete.^{1/}

TYPES OF CONTRACTS OFFERED

Most Blue Cross plans offer what is known as a "semi-private" contract. Of the 81 plans (continental United States only) 68 offer such a contract. (See Appendix Table D-1.) Of these, 23 also offer a "ward contract" and 3 a "private room" contract. Seven plans offer a ward contract only and six offer both ward and private room contracts. No plan offers a private room contract only.

These designations of the contracts of the plans are those generally used by the plans themselves or by the Blue Cross Commission. However, the designations are in part simply labels of convenience and need to be understood in the light of the fact that definitions of the various types of accommodations vary from plan to plan, that in some areas accommodations considered semi-private would elsewhere be considered ward, and vice versa, and that some plans define the room accommodations furnished in terms of a dollar room allowance which may or may not suffice to provide in all or most of the hospitals of the area the type of accommodations designated by the label of the contract.

Thus, most of the plans with so-called semi-private contracts define a semi-private room as one with two or two to four beds (See Appendix Table D-1). One defines it as a room with two to six beds, another as a room with three to five beds. Some of the plans do not define the term in their contracts and the hospital provides what it considers to be a semi-private room. A goodly number of the plans -- almost a third -- with so-called semi-private contracts

* All data as of Dec. 1, 1946 unless otherwise noted.

^{1/} As part of the survey, copies of subscriber contracts were obtained from all plans as of July 1, 1945 and tables were compiled similar to those in Appendix D showing the contract provisions. However, by the time this report was ready for publication all of this material was so out-dated that it was decided not to use it, but to rely upon the published data of the Blue Cross Commission instead.

provide dollar room allowances, ranging from \$3.00 to \$6.00. These contracts are labelled semi-private because the dollar room allowance approximates, or originally (when the contract was first issued) approximated the cost of a semi-private room in most or all of the hospitals of the area. However, these contracts do not assure care in semi-private accommodations.

Similarly, the plans offering ward contracts have different definitions of what is meant by ward accommodations (many do not define the term) and some provide a dollar room allowance (ranging from \$3.00 to \$5.00) which may or may not meet the cost of a ward bed.

The situation being what it is perhaps the most accurate way of summarizing the contracts issued by the plans would be to say that of approximately 113 main or standard contracts^{2/} issued by the 81 plans, 5 provide care in a private room, 48 provide care in semi-private accommodations as these are defined by the plan or the hospitals of the area, 30 provide care in ward accommodations, and 30 provide a dollar room allowance.^{3/}

The type of contract offered by a plan is determined very largely by the availability of the various types of accommodations in the area served by the plan, and by the relative popularity of these accommodations among the types of people that the plan reaches or hopes to reach. In areas where the hospitals have large numbers of semi-private rooms and where this is the type of accommodation generally used by persons of moderate means, the plan will offer a semi-private contract. In the south the hospitals have few semi-private rooms and mainly offer either ward or private room service. For this reason most of the southern plans offer ward contracts or ward and private room contracts. In the Pacific Coast States, the hospitals have few so-called semi-private beds. The plans in these States offer contracts which provide care in rooms with three or four beds, i. e., accommodations which are termed ward but in the east would be considered semi-private.^{4/}

2/ This chapter is restricted to the main or standard contracts of the plans. A few of the plans have special or subsidiary contracts in addition.

3/ The provision by some plans of a dollar room allowance instead of care in specified accommodations is a recent development. In part the development is due to the fact that such a definition of the room accommodations to which the subscriber is entitled is a more precise one than, say, a "semi-private" room. Thus, a given hospital may have several types of semi-private rooms with differing rates, and some of its semi-private rooms may be more costly than some of its private rooms. Also some hospitals may charge more for their semi-private rooms than other hospitals charge for their private rooms, and a dollar room allowance, in effect, gives all subscribers rooms of equal value irrespective of the hospital used. The tendency toward definition of room accommodations in terms of dollars is also due in large part to the fact that as hospital costs have mounted, the difficulties of the plans and hospitals in reaching agreement as to a fair rate of remuneration have increased. Specification of the room accommodations to be furnished in terms of a dollar allowance tends to remove the room cost from the area of dispute and thus facilitates agreement as to remuneration of hospitals. However, it is recognized that this procedure puts the plan in the position of offering indemnity (dollar) rather than service benefits, and there is much dispute among the plans as to whether the tendency is a wholesome one.

4/ In most plans which offer both semi-private and ward contracts, the former is the more popular -- in fact in some plans the proportion of people holding the ward contract is very small. In 11 plans the proportion of total participants having the ward contract is (1944 data) as follows: Michigan 45, Massachusetts 14, Philadelphia 1, Rhode Island 20, Toledo 46, Utica 7, Texas 8, Wilkes-Barre 17, Delaware 4, Oklahoma 13, Cincinnati 31.

The extent to which subscribers or potential subscribers have been inclined towards the ward contract, in plans where both ward and semi-private contracts are offered, has diminished very perceptibly in recent years. Several plans brought forth ward contracts in 1939 or 1940, and the reception to them seemed promising. However, these plans now have virtually ceased to offer these contracts because of the lack of subscriber interest. Whether this situation will continue with changing economic conditions remains to be seen.

SUBSCRIPTION RATES

Subscription charges for the semi-private contract range, for the most part, from \$.75 to \$1.00 a month for a single person, from \$1.50 to \$2.00 for two persons, and from \$2.00 to \$2.50 for a family. (See Appendix Table D-2.) Some plans have a dual rate structure, one charge for a single person and another for a husband and wife or a family. Typical dual rates are \$.75 and \$2.00, or \$1.00 and \$2.25 or \$2.50. Subscription charges for the ward contract usually run about a third or a quarter lower than for the companion semi-private contract. Typical rates are \$.60, \$1.20 and \$1.50 or simply \$.60 and \$1.50 ⁵/

Under the family contracts the husband and wife and all dependent unmarried children under specified ages are entitled to care.⁶/ The age limit for eligible dependent children varies from plan to plan; in most plans it is 18 or 19.⁷/ A majority of the plans do not provide care to newborn infants during the first few months of life. In July 1945 out of 79 plans, 20 plans extended coverage to newborn infants only after 30 days; 6 plans extended such coverage only after 60 days; 18 plans accepted infants only after 90 days; 2 plans after 4 and 6 months respectively; 3 plans only after 12 months. One plan permitted the addition of a child only at the beginning of the parents' next contract year. The remaining 29 plans had no such provision and extended coverage to infants from the day of their birth. Some of the plans which exclude infants from coverage under the terms of their contracts do not in practice enforce this provision, but supply care to all infants whose parents have family coverage.⁸/

A few (10) of the plans do not provide full benefits to dependents. (See Notes to Appendix Table D-4.) In these plans the dependents make a certain payment to the hospital, usually \$1.00 for each day of care received. These plans usually have relatively low husband and wife and family rates. Partial dependent coverage was inaugurated by the Minnesota plan in the early days of the movement when it was not certain that families could be "sold" on the idea of paying the rates which would be required to furnish full coverage. Exper-

⁵/ The dual rate structure is now used by 23 plans in their semi-private or higher cost contract. The number is constantly growing. Many of the recently established plans have adopted this rate structure, and some of the older plans have changed over. The dual rate structure has many advantages. It simplifies administration; there is no need to change the contract when a child is added or dropped; and it is simpler to present to the public. Under the triple rate structure of most plans, where the charge for husband and wife is double that for the individual, the proportion of income used for hospitalization has usually been considerably greater for husband and wife contracts than for single person or family contracts. This means that the husband and wife contracts are contributing relatively less to the maintenance of the plan as a whole than the other two types of contracts. Under the dual rate structure, single persons and husbands and wives will contribute relatively more to the maintenance of the plan than families, which is a fairer arrangement since the former two groups usually have a greater ability to pay.

⁶/ About a third of the plans accept so-called sponsored dependents, i. e., dependents, living with the subscriber, other than the spouse and eligible children. The charge for each such dependent is usually the same as that for a single person.

⁷/ As of July 1, 1945 in 79 plans, the age limit was 16 in 1 plan, 18 in 22 plans, 19 in 53 plans and 21 in 3 plans.

⁸/ The reasons for these restrictions on the care of infants are not clear, and many of the plans with these restrictions do not seem to offer a clear explanation of the need for them. In part the restrictions may flow from administrative considerations. Undoubtedly some of the plans have this restriction because they believe, rightly or wrongly, that infants during the first few months of life are poor risks. Perhaps it would be more accurate to say that this last was the original reason for the restriction and that many of the plans have never re-examined this assumption.

ience has demonstrated that people prefer to pay a little more and receive full coverage and one after another plans which have had partial coverage of dependents have gone over to full coverage.

The subscription rates set forth in Appendix Table D-2 are those paid by group subscribers who pay through their place of employment. A good many of the plans charge higher rates to individually enrolled or "group conversion" subscribers -- subscribers who make direct payments to the plan usually on a quarterly, semi-annual or annual basis. The reasons for the higher rates charged to these subscribers are the higher cost of handling these accounts and the desirability of giving such subscribers an incentive to transfer to payroll deduction groups wherever that is possible.

It is interesting to compare the rates charged by the various plans. Probably the best basis of comparison is the family rate charged for the semi-private contract by plans which offer full dependent coverage. Of 59 plans, 10 charge less than \$2.00; 23 charge exactly \$2.00; 23 charge between \$2.01 and \$2.50; 3 charge over \$2.50.

ENROLLMENT FEES

An enrollment fee, usually \$1.00, is charged by 18 of the plans. (See Appendix Table D - 2.) This fee is the same for an individual or family subscriber. The charging of enrollment fees was far more common years ago; it is gradually being discarded.^{9/}

DAYS OF CARE PROVIDED

Appendix Table D-3 shows the days of care provided. Approximately half of the plans provide a maximum of 21 days of care during the first year of membership. The majority of these increase the days of care in subsequent years providing, for example, 25 days in the second contract year and 30 days in the third and subsequent years of membership. Some 28 of the plans provide 30 or 31 days of care per contract year and a few 40 or 60 days or thereabouts. Generally these latter plans do not increase the number of days of coverage in subsequent membership years.

The great majority of the plans provide partial coverage for an additional period after the period of full coverage. The most common provision is a 50 percent discount, on those items of the hospital bill which the plan covers, for a period of 90 days after the cessation of full coverage.

A small but growing number of plans (8) provide full coverage for a certain number of days per hospital admission or for each distinct illness, instead of so many days per contract year. This provides greater protection to the member and also simplifies administration. The number of days provided by these plans ranges from 21 to 90. A few plans have developed special contracts which are offered to large groups with a high percentage of enrollment. Thus the "comprehensive" contract of the Rhode Island plan (offered to large groups with 90 percent enrollment) provides 150 days of care per year, not more than 75 days being allowed for the same cause. The comprehensive contract of the Massachusetts plan provides 120 days per admission.

The average hospital stay of Blue Cross members is eight days. Coverage for 21 days will provide complete protection in about 94 percent of all gener-

^{9/} In July 1945 23 of the plans charged such a fee.

al hospital cases and will pay the bill for about 76 percent of all hospital days. (See Chapter 12.)

HOSPITAL SERVICES PROVIDED

Appendix Table D-4 shows the hospital services which are furnished to subscribers. All of the plans provide room and board (or a dollar allowance towards the cost). All provide the general nursing service of the hospital and use of the operating room. All but eight provide whatever special diets the patient may require.

A majority of the plans (65 of the 81) cover to some extent the administration of anesthesia. The great majority of these plans provide this service when it is given by a salaried employee of the hospital. A few of the plans will also pay the fee, up to a certain amount, charged by a physician for the administration of anesthesia. Some 15 plans cover hospital charges for anesthetic supplies but not the charges for the administration.

In this field, and also with respect to pathology, x-ray and certain other services, the plans conform to prevailing practices in the area and the desires of hospitals and the medical profession. In those areas wherein it is the prevailing practice for anesthesia to be administered by nurse anesthetists employed by the hospitals, this service is commonly considered to be a hospital service and is covered by the plan. In areas where anesthesia is commonly given by physicians paid on a fee basis, this service is often considered a medical rather than a hospital service and has not been included under the plan unless the medical profession so desired. Where the plan offers medical service contracts or has an affiliated medical plan, the administration of anesthesia when not covered by the hospital plan will always or almost always be covered under the medical contract.¹⁰

All plans cover laboratory services to some extent. Some provide only what is described as routine laboratory service, which usually consists of blood count, urinalysis, and coagulation test, while others provide complete laboratory services including examinations of pathological tissues. Again the extent of laboratory services offered under the plan is largely determined by prevailing relationships in the area between hospitals and pathologists, and the desire of the latter that their services should or should not be included under the plan. Again pathology services not offered under the hospital plan will be offered under the companion medical contract, if any.

All plans provide drugs to some extent. A majority of the plans (58) provide all drugs that may be prescribed by the physician, including penicillin. Most of the remaining plans provide what are described as "ordinary" or "routine" medications. In most cases this would mean all drugs that the hospital is equipped to provide from its pharmacy except a certain few expensive drugs such as penicillin. The great majority of the plans provide all dressings, including casts and splints, that may be necessary. Others provide only "ordinary" dressings, casts and splints.

X-ray service is covered to a greater or lesser degree by 51 plans. Of these, 23 provide whatever service may be necessary, while the remainder give only partial coverage. Most of the latter plans furnish the services up to a dollar limit, frequently \$15.00. What has been said above relative to anes-

¹⁰ The problems of the inclusion of anesthesia, pathology, radiology and physical therapy services in hospital and medical plans are discussed in chapter 23.

thetia and pathology services also applies here. In many localities the inclusion of x-ray services has been a bone of contention among the hospitals, the medical profession and the plan. Roentgenologists have often maintained that x-ray services, being medical services, should not be included in a hospital plan. Hospitals have often maintained that these services, being provided through equipment owned by the hospital and the charges being generally included on the hospital bill, are hospital services and should be included in the plan.

Basal metabolism tests are covered (in full or subject to certain limits) by 59 plans, the provision of oxygen by 58, electrocardiograms (usually the making of the test but not its interpretation) by 43 plans. Use of the physical therapy equipment is covered by 41 plans. Emergency room service (usually limited to the first visit within 24 hours of an accident) is covered, to some extent, by 69 plans. Ambulance service, usually limited, is furnished by 13 plans.

It will be seen that there is considerable diversity among the plans in the services covered and not covered. Some plans by providing little more than room, board, use of the operating or delivery room, and routine drugs, may leave the hospitalized subscriber, especially one who needs elaborate laboratory and x-ray services, with an appreciable bill to pay when he leaves the hospital. Other plans provide a complete service, and the subscriber who takes the room accommodations furnished by his contract and does not have an over-long stay, will have no hospital bill whatever to pay, unless it be charges for guest trays and telephone calls.

COVERAGE OF CERTAIN SPECIAL CONDITIONS

All of the plans have special provisions as regards maternity care and many either exclude certain other types of cases from coverage or impose special limitations on the care provided.

MATERNITY CARE

All of the plans provide service for maternity cases, but all, in order to protect the plan against adverse selection of risks, provide that such care will be furnished only if the patient has been a member of the plan for at least a certain period. The required waiting period is 6 months in the case of one plan, 7 months in another, 8 months in another, 9 months in 15 plans, 10 months in 40 plans, 11 months in 3 plans, 12 months in 20 plans.^{11/} (See Appendix Table D-5.) Many plans -- 15 of the 39 plans which were personally visited in 1944 and 1945, and the proportion is certainly higher now -- waive the maternity waiting period for large employed groups where 75 percent or more of the employees enroll.

Most of the plans will provide maternity service only to persons enrolled under a husband or wife or a family contract; 25 plans provide this care only under a family contract.

The majority of plans, in order to prevent abuse, place a limit upon the number of days for which care will be provided in uncomplicated maternity cases. This limit is usually 10 days. Most plans give full service benefits

^{11/} Two plans (Massachusetts and Rhode Island) have special "comprehensive" contracts, sold to large groups with a high percentage of enrollment, under which there is no waiting period.

during the allowed quota of days; some plans place a dollar limit upon the care which will be furnished, or require the patient to pay a portion of the cost.

NERVOUS AND MENTAL CONDITIONS

Most general hospitals do not accept so-called nervous and mental conditions, at least those diagnosed as such. The plans were largely organized by general hospitals and were designed, it was thought, primarily to cope with the problem of general illness. Hence, most plans, at least in the beginning, excluded nervous and mental conditions from coverage. In recent years a tendency to provide care for these cases for a limited duration has been manifest.

At present (See Appendix Table D-6) 41 of the 81 plans in the United States provide some coverage for these conditions, although only 17 of these plans provide the same duration of service as for general illness and some provide the care only in member or general hospitals and not in mental hospitals. Seven plans provide care until the condition has been diagnosed, and 33 plans provide no care in these conditions.

TUBERCULOSIS

The situation with respect to tuberculosis is roughly similar to that for nervous and mental cases and generally each plan has the same provisions for both. Forty plans give some coverage for this disease. Only 10 of these give the same duration of care as for general illness and a few provide the care only in member or general hospitals. Twelve plans provide benefits until the condition has been diagnosed, and the remainder exclude care for this disease.

QUARANTINABLE DISEASES

The situation with respect to these diseases is roughly comparable to that for mental disease and tuberculosis. At present (See Appendix Table D-6) 58 plans provide some coverage and 23 do not. A majority (34) of the plans which cover these diseases provide the same duration of care as in general illness; most of the others provide the same number of days at full benefits but give no partial benefits for any further period. A few of the plans provide benefits only in member hospitals.

PRE-EXISTING CONDITIONS

Up-to-date information on the provisions of the plans with respect to these conditions is not available. At the time of our own study of the contracts of the plans, in July 1945, 45 out of 79 plans stated in their contracts that care for pre-existing conditions, i. e., conditions which existed prior to enrollment or for which care had been advised prior to enrollment would not be furnished. An additional 11 plans provided that care would be

furnished for such conditions only after a waiting period, usually 1 year. The remaining 23 plans provided care for pre-existing conditions without qualification.^{12/}

The reason for this exclusion, where it exists, is to avoid providing care to persons who learn of some condition requiring hospitalization and then join the plan simply to receive care for this condition. However, the discernment of cases hospitalized for care of pre-existing conditions presents difficulties. To weed out such cases a plan would have rigorously to scrutinize the diagnosis on each hospital admission and in suspected cases request information from the attending physician on the history of the case. Few plans which exclude pre-existing conditions in their contracts do this. Most of them feel that such rigorous policing would cost them more than they would save, and they are content simply to reject an occasional flagrant case -- "the member who signs up on his way to the hospital."

A constantly growing number of plans accept pre-existing conditions without qualification. These plans rely on enrollment of high percentages of persons within groups to assure an average selection of risks in this regard. A good many plans, which state in their contracts that they exclude pre-existing conditions, waive this exclusion in the case of large groups where more than a 75 percent enrollment is obtained.^{13/}

ADMISSION FOR DIAGNOSIS ONLY

A majority of the plans (47 out of 79 in July 1945) state in their contracts that care will not be provided in cases where the patient is admitted to the hospital for 'diagnosis only'.^{14/} Many of the plans which accept such cases do not provide x-ray or complete laboratory service, so that the plan gives little incentive to the subscriber to enter the hospital for diagnostic services only.

There are two main reasons for this exclusion. One is so that the plan may avoid providing care to persons who do not need care as bed patients but simply wish to avail themselves of the diagnostic services offered by the plan. Another reason is that if these cases were accepted the plan would be encouraging a possibly unfair type of competition between hospital x-ray and laboratory departments and roentgenologists and laboratories not associated with hospitals.

From an administrative standpoint the exclusion of this type of case presents difficulties for both the plan and physicians. In practice the plans are undoubtedly accepting many cases of this sort. They do so because the attending physician, who is aware that his patient is a subscriber and can receive x-ray and laboratory services without direct cost if hospitalized, will so word the admitting diagnosis that it will not appear that admission was solely or primarily for diagnosis. In the course of the survey a few physicians complained to the writer that the situation puts them under pres-

^{12/} A recent study of the Blue Cross Commission (Feb. 1947) finds that of 80 U. S. plans, 36 cover pre-existing conditions, 10 cover them after a waiting period and 34 do not cover these conditions.

^{13/} Virtually all of the plans which waive the waiting period for maternity benefits in the case of large groups with a high percentage of enrollment also waive the exception of pre-existing conditions, if they have this exception, for the same groups.

^{14/} The Blue Cross Commission reports that in February 1947, 42 U. S. plans covered these cases, 38 did not.

sure to perjure themselves. It is doubtful whether there can be any good solution to this problem unless and until plans are developed providing physicians' services, including x-ray and laboratory services, to non-hospitalized patients.

OTHER CONDITIONS

Venereal diseases were excluded from coverage by many of the early plans. As of July 1945, 46 of the plans covered these cases and 33 did not.^{15/} Many of the early plans excluded care for alcoholism and drug addiction. The trend is towards coverage of these conditions. In July 1945, approximately 60 per cent of the plans covered them. These cases arise so infrequently that plans save very little by excluding them or incur very little cost through covering them. Self-inflicted injuries were not covered by nine plans in July 1945, and congenital defects by seven plans.

All of the plans exclude from coverage cases for which care is available under workmen's compensation. One plan -- the Massachusetts plan -- will in the case of its semi-private contract holders pay the hospital charges for the difference between a semi-private room and the ward accommodations to which the person is entitled under workmen's compensation. With one or two exceptions, the plans do not pay for care received in veterans' hospitals or in other governmental facilities wherein the patient receives or can receive care free of charge.

ALLOWANCES TOWARDS BETTER ACCOMMODATIONS.

All of the plans permit members to take better accommodations in the hospital than those to which they are entitled under their contract. Thus a ward contract holder may at the time of hospitalization take a semi-private or private room and the semi-private contract holder may take a private room. To the patient who does this, the plan provides an allowance more or less equivalent to the cost of the care to which he was entitled, towards the cost of the better accommodations.

The more common provision, which obtains in 47 of the plans, (see Appendix Table D-7) is that the member is entitled to the special hospital services provided under his contract and receives an allowance of a fixed amount, commonly \$4.50 or \$5.00, towards the cost of the better accommodations. This fixed amount usually represents the prevailing or usual charge for semi-private or ward accommodations, as the case may be, in the area. In 22 plans the member receives all special services and pays the hospital the difference between its charges for the accommodations to which he is entitled and the accommodations which he chooses.

A number of plans provide a less advantageous arrangement. For example, the Philadelphia plan provides the member who takes better accommodations with (a) a dollar allowance towards the room cost, and (b) credits for the special hospital services equivalent to the hospital's regular charges for these services to semi-private patients. The patient pays the difference between these credits and the hospital's actual charges. The New York City plan provides the member with what is essentially an indemnity equivalent to what the plan would have paid the hospital had the member taken a semi-private room, or

^{15/} In February 1947, 52 plans covered these cases, 28 did not.

alternatively a certain number of dollars per day of stay.¹⁶ The necessity of these arrangements flows out of the fact that hospitals in some areas customarily vary their charges for the special services in accordance with the type of room accommodations used by the patient. Thus the private room patient will pay more than a semi-private patient for use of the operating room, etc.

Appreciable proportions -- generally from 20 to 40 percent -- of subscriber-patients take better accommodations than their contract calls for. Some sample figures are: The New Jersey plan, 19%; the New York City plan, 25%; the Rochester plan, 30%; the Cincinnati plan, 29%; the Maryland plan, 35%; the Colorado plan, 40%; the Kansas City plan, 40%; the Wilkes-Barre plan 50 percent.

NON-MEMBER HOSPITAL ALLOWANCES

All plans pay certain amounts towards meeting the hospital bills of members who are hospitalized in non-member hospitals. Non-member hospitals may be institutions within the plan's area, which have not been accepted as or do not desire to become member hospitals. Far more generally they are hospitals outside the plan's area. About nine percent of hospitalized subscribers receive care in non-member hospitals; in the great majority of these instances the subscriber is hospitalized outside the plan's territory.

The usual allowance for care in non-member hospitals, whether outside or within the plan area, is payment of the hospital's charges up to, but not exceeding, a fixed amount per day. (See Appendix Table D-8.) The typical payment is up to \$6.00 per day under semi-private contracts or up to \$4.50 or \$5.00 per day under ward contracts for each day of full coverage and correspondingly lowered amounts for each day of any further period for which the plan provides partial benefits. Some plans provide higher allowances for short stay cases. For example, the New York City plan pays up to \$15.00 for a one day stay, \$25.00 for two days, \$34.00 for three days, etc. The California plans will pay non-member hospitals, in or out of the State, their regular charges for the services and accommodations provided under their contracts.

INTER-PLAN SERVICE BENEFIT AGREEMENTS

The limited payments made by most plans for subscribers hospitalized outside of the plan area will usually fall short of covering the bill, and this is recognized as a disadvantage. To overcome this the central organization of the plans has fostered a program of reciprocity agreements among the plans for the provision of service benefits in out-of-the-area cases. Under these arrangements if a member of plan A enters a member hospital of plan B with which it has a reciprocal agreement, the member receives the service benefits of plan B. Plan B pays the hospital for its services at its contractual rates and secures reimbursement from plan A.

Virtually all plans which have entered into these agreements give the member the option of either receiving the plan's own non-member hospital allowances or the service benefits of the "host" plan, whichever will be of

¹⁶/ This has recently been changed so that the subscriber who takes a private room receives a \$6.00 room allowance and all of the special services.

greater benefit to him. Where the service benefits of the "host" plan are meager and the "home" plan provides generous non-member hospital allowances the member may be better off with the latter. Generally, however, the subscriber will find it to his advantage to take the service benefits of the "host" plan.

The inter-plan service benefit program has two parts. Plans participating in Part I request service benefits for their subscribers hospitalized in the areas of other participating plans. Plans participating in Part II agree to provide their service benefits to subscribers of other participating plans. As of February, 1947, (see Appendix Table D-9) 37 plans with about two-thirds of the total enrollment in all plans are participating in both parts of the program. A few plans are participating in Part II but not Part I.

The inter-plan service benefit program, on its present basis, has disadvantages for certain plans -- those in low cost hospital areas or which have less comprehensive benefits than other plans -- and many of these have refused to participate. The program asks these plans to pay more for the care of their subscribers outside their territory than they would pay within it. On the other hand the program is easy on the plans with high cost hospitals and comprehensive subscriber benefits. It costs these plans less to provide the service benefits of other plans than to provide their own service benefits.

Because of the above factors the inter-plan service benefit program, on its present basis, has probably gone about as far as it can go, i. e., the plans which have thus far refused to participate will probably continue to do so. Hence the plans are giving consideration to other approaches to the problem. The approach being given most consideration is one proposed by Mr. Webb, the executive director of the Maine plan. He proposes that the Blue Cross Commission set up an Inter-Plan Service Benefit Bank. Each plan would, in effect, pay to this bank for each day of care provided by other plans to its subscribers an amount equal to *its average per diem payments to its own member hospitals*. Subscribers would receive the service benefits of the "host" plan; the latter would pay the hospital at its regular rates and would be reimbursed by the bank. In other words the plans as a whole would share the burdens of providing reciprocal service benefits. Any net gain or deficit incurred by the bank would be shared among the plans pro rata.

PERIOD OF CONTRACT

In the early days of the movement the plans tended to issue subscriber contracts which could not be cancelled or revised by the plan except at the end of a year. This was found to be disadvantageous in one important respect. It meant that if a plan wished to change its rates or benefits, it would only do so gradually over a year's period, each subscriber's contract being cancelled as it expired and the revised contract substituted. This situation, as compared with one in which the plan could revise all its contracts at one time, increased the administrative cost of any revision of contracts and impaired the ability of a plan quickly to adjust its rates and benefits in case of need. In recent years more and more of the plans have issued contracts which are cancellable on short notice. As of July 1945 almost three-fourths of the plans had contracts which could be cancelled or revised on notice of 30 days or less; the remainder had contracts which could only be cancelled or revised at the end of the contract year.

A PROPOSED NATIONAL CONTRACT

The plans have recognized that greater uniformity in their benefits would be desirable. The diversity in benefits is an especial handicap in the enrollment of national concerns; such concerns particularly when they are paying part of the cost, desire that all of their employees wherever located should receive the same benefits.

In an endeavor to obtain uniformity of benefits representatives of the plan agreed in 1944 to recommend to their respective plans adoption of a so-called national contract. A plan could offer this contract to all of its subscribers or could make it available as a special offering solely to employees of national firms.^{17/}

Few of the plans actually adopted the proposed national contract, and at present the issue is no longer a live one. However, since the adoption of this resolution many of the plans have revised their benefits so as to bring them nearer or up to the level of the proposed national contract. At the same time a considerable number of other plans have offered benefits which in certain respects go beyond those of the national contract. As a result of this process, the plans have made progress towards provision of more comprehensive care but have approached little, if any, closer to uniformity of benefits. It is doubtful if uniformity of benefits can be attained until the plans provide completely comprehensive service.

THE TREND TOWARDS MORE COMPREHENSIVE BENEFITS

There has been a consistent trend among the plans towards the provision of more comprehensive benefits. Some indication of the strength of this tendency is called for.

In November 1943, among the 74 plans in the United States, 57 plans had a duration of service of less than 30 days during the first year of membership, 16 provided 30 days or more and one provided 30 days per admission. In December 1946, out of 81 plans, 41 provided less than 30 days per year, 33 provided 30 days or more and 7 provided 21 days or more per admission. In November 1943, 15 out of 74 plans provided only partial benefits to dependents. In December 1946, 10 out of 81 plans provided partial benefits to dependents.

With respect to the special services, in November 1943, 47 out of 74 plans provided complete coverage of drugs and medicines; in December 1946, 59 out of 81 plans provided this coverage. In November 1943, 26 of 74 plans provided some coverage of electrocardiograms, in December 1946, 44 out of 81 plans. In the former period, 34 plans provided emergency room service, in the latter period, 63 plans. In November 1943, 41 and 50 plans (out of 74)

^{17/} The contract provided 30 days of care each year and an additional 90 days at 50 percent benefit. All conditions would be covered except that care for mental disease and tuberculosis would be provided in member hospitals only and for not more than 30 days. Care for quarantinable diseases would be limited to \$3.00 per day (\$1.50 after 30 days) and care for maternity would be limited to 10 days with a waiting period of 9 months. This waiting period would be eliminated for those groups where 75 percent of all employees and at least 50 employees enrolled. Pre-existing conditions would be covered. The hospital services provided would be semi-private room, use of operating and delivery room, all drugs and dressings (except blood and blood plasma), x-ray examinations up to \$15.00, complete laboratory service, anesthesia up to \$10.00, plaster casts, basal metabolism tests, oxygen therapy and use of cystoscopic room, cardiographic equipment and physiotherapeutic equipment. The same benefits would be available in the member hospitals of all plans. For care in non-member hospitals an allowance of up to \$6.00 per day would be made.

provided some coverage of x-ray and anesthesia service, respectively; in December 1946, 49 and 65 plans (of 81) provided some coverage. In the former period 43 plans provided complete laboratory service, in the latter period, 50. (The main movement towards coverage of these last three services has come through the development of allied medical plans providing this coverage.)

With respect to conditions and diseases covered: In July 1945, 31 of 79 plans gave some coverage of tuberculosis, in December 1946, 40 of 81. In July 1945, 31 of 79 plans gave some coverage of mental illness; in December 1946, 41 of 81. However, there appears also to be a trend towards cutting down the period of coverage for these diseases, i. e., restricting service to not over 21 or 30 days.

EXTENT OF COVERAGE OF THE HOSPITAL BILL

Data on the extent of coverage of the subscriber's hospital bill were obtained from about half of the plans surveyed. The figures that were obtained took various forms and are not easily comparable. They are set forth in the accompanying table (Table 6).

Figures for 20 plans show that the percent of the hospital bill covered (for the period of full and partial days of service) ranged from 62 to 86 percent.¹⁸ Two of the plans with less than 70 percent coverage gave only partial coverage of dependents. A large proportion of hospital charges not covered represents the cost of better accommodations. Subscribers who took the accommodations provided by their contract had 77 to 95 percent of the bill covered. Those who took better accommodations than their contract provided had 43 to 71 percent coverage of the hospital bill.

¹⁸/ Very few general hospital cases (6/100 of one percent) have a hospital stay of more than 111 days, which is the period of full plus partial coverage of most of the plans, and the proportion of all general hospital days not included in this period of coverage is inconsequential (about one percent).

TABLE 6

Percent of Subscriber's Hospital Bill Covered by Plan
(Data from Certain of the Surveyed Plans)

PLAN AND APPROXIMATE PERIOD TO WHICH DATA RELATE	SUBSCRIBERS TAKING ACCOM- MODATIONS SPECIFIED IN CONTRACT (SP=Semi-Private, W=ward)	SUBSCRIBERS TAKING BETTER ACCOMMODATIONS THAN THOSE SPECIFIED IN CONTRACT	ALL SUBSCRIBERS
LOS ANGELES, CAL (1946)	90.	%	75.
COLORADO (1946)	-	-	73. (approx.)
DELAWARE (1946)	SP86.-W90	71.4	81.2
KANSAS (1946)	-	-	68.
MARYLAND (1946)	-	-	78.
MICHIGAN (1946)	-	-	86.2a/
MINNESOTA (1946)	-	-	62.4b/
KANSAS CITY, MO. (1946)	80.-85.	60.	82.5 (approx.)
CINCINNATI, OHIO (1946)	-	-	79.
PHILADELPHIA, PA. (1946)	SP88.-W84.	56.	83.8c/
RICHMOND, VA. (1946)	91.1c/	-	81.6
ROANOKE, VA. (1946)	-	-	-
ALABAMA (1944)	-	-	80.
ATLANTA, GA. (1944)	-	-	85.2
MASSACHUSETTS (1944)	90.3d/	-	-
ST. LOUIS, MO. (1944)	85.1e/	42.7e/	67.6/
NEW YORK CITY, N.Y. (1944)	76.7	57.2	64.7e/
ROCHESTER, N.Y. (1944)	95.f/	60.f/	-
CHAPEL HILL, N.C. (1944)	-	-	-
WILKES-BARRE, PA. (1944)	-	-	78.6
NORFOLK, VA. (1944)	-	-	73.1

a/ Probably applies to period of full coverage only.

b/ Plan gave only partial coverage to dependents at this period.
Under new contract a much larger proportion of the bill will be covered.

c/ For period of full coverage only.

d/ Under new "comprehensive" contract subscribers receive complete hospital care for up to 120 days.

e/ Figures in the first two columns are for non-maternity cases only. The hospital bill includes charges for special nurses.

f/ Estimate.

CHAPTER 5

MEMBER HOSPITALS AND THEIR REMUNERATION

Blue Cross plans provide hospital services to subscribers through contracts with their "member" hospitals, the member hospital agreeing to furnish the specified services to subscribers in return for certain payments by the plan.

WHICH HOSPITALS MAY BECOME MEMBER HOSPITALS?

Three factors determine which hospitals in the area of a plan are or may become member hospitals: first, the requirements, if any, set forth in any State law governing the operation of the plan; second, the requirements or standards which the plan itself may set up; and third, the desire of the particular hospital to become a member hospital. These will be discussed in turn.

Laws providing for the establishment of non-profit hospital service plans have thus far been passed in 34 States and the District of Columbia.^{1/} These laws will be discussed in a later chapter. It suffices to say here that of the 35 laws 22 set up certain requirements which hospitals must meet in order that the plan may contract with them for the provision of service. In 15 States plans may contract only with hospitals approved by a State agency--generally the State welfare, insurance or health department, or by two of these departments. In four States the plans may contract only with hospitals approved by a private agency--the American Hospital Association, the American Medical Association, the state hospital association, or the state medical society, or by two of these organizations. In three States the plans may contract only with non-profit or governmental hospitals.

None of the laws requiring approval of member hospitals by a State agency sets up any standards on the basis of which the State agency shall grant or withhold approval. In those States which have a hospital licensing act and which require approval of member hospitals by a State agency, the State agency which licenses hospitals will generally be the one to which is delegated the responsibility of approving member hospitals. This State agency will then generally approve any hospital which it has licensed. State insurance departments are not well qualified to pass on the qualifications of hospitals, and where these departments are delegated the responsibility of approving member hospitals it generally means that the department approves any hospital which the plan believes should be approved.

In addition to any legal requirements, the plans may have certain rules of their own as to which hospitals will be accepted as member hospitals. Of course where there are no legal requirements, then the plan's own rules are

^{1/} As of May 1, 1946.

the sole governing factor. Data as to eligibility requirements for member hospitals are available only for the 39 plans personally surveyed. Of these 39 plans, 10 plans will accept as member hospitals only hospitals registered by the American Medical Association. Five plans, including the three where this requirement is written into the law, will accept only non-profit hospitals. One plan accepts only hospitals approved by the American College of Surgeons, but this high standard was adopted because it happens that all of the hospitals in its area which the plan wishes to accept are approved by the College. Most of the plans do not have formal or crystallized eligibility requirements of their own. They will accept any hospital which meets the requirements set forth in the law or which is deemed by the plan's board of directors to be reputable and to be meeting a community need.

In general, the eligibility requirements of the plans are not at all strict. The Minnesota plan is an exception to the general trend in that it has very explicit requirements. Member hospitals must be non-profit, and have the approval of the American College of Surgeons, or the American Medical Association, or the State or county medical association. The medical staff of the hospital must certify that it wishes the plan introduced in the community. The hospital must have an organized, open medical staff, maintain adequate records, have adequate nursing service, laboratory facilities, competent personnel, and a good physical plant. It must submit a financial statement. The director of the plan, a former hospital superintendent, inspects each institution desiring membership. The plan has steadfastly refused to admit proprietary hospitals, and over the course of years a considerable number of formerly proprietary hospitals in this State have changed to a non-profit status in order to become members.

Few, if any, of the plans exclude from membership tuberculosis or mental hospitals. Nevertheless, few plans do have tuberculosis and mental hospitals as member hospitals. The great majority of plans do not provide care for these conditions or offer such limited care that it would not be any particular advantage to the plan to have such hospitals as members or any advantage to these hospitals to be members. No Blue Cross plan (to our knowledge) refuses participation to governmental hospitals but the number of such hospitals which participate in plans is relatively small. The reason is that many governmental general hospitals which serve the general community accept charity patients only.

The third factor in determining which hospitals in an area are member hospitals is the desire of the individual hospital to participate in the plan. Generally hospitals desire to participate because the plan is beneficial to them and to the public. In fact the great majority of plans have contracts with all the eligible general hospitals of their area. In an area with a well established plan a hospital would find it urgently desirable to be a participating hospital, and if it were not accorded this privilege it might be seriously handicapped. This follows from the fact that subscribers are accorded greater benefits in member than non-member hospitals, and accordingly prefer to go to member hospitals when they have the choice. From a standpoint of equity it is exceedingly important that hospitals which desire to become member hospitals of a plan should not be denied this privilege except on fair grounds.

The determination of whether certain hospitals of low or questionable standards should be accepted as member hospitals poses difficult problems for a plan. In offering the services of its member hospitals to its subscribers

a plan assumes a certain responsibility for the quality of service rendered. A plan is naturally reluctant to offer its subscribers the services of an unworthy institution. On the other hand a plan must face the fact that such hospitals are serving the general public and that the primary purpose of the plan is to prepay hospital costs, not to raise hospital standards. A plan which puts its standards so high that it rules out hospitals in which any appreciable portion of the population is accustomed to receiving service is apt neither to be very successful nor to perform a great service to the people of the area.

A few plans do not accept proprietary hospitals as members. If this rule were applied to Alabama, for example, it would rule out well over half of all hospitals in the State which are registered by the American Medical Association. In such a State a plan could not very well be established if it refused to accept proprietary hospitals. On the other hand the character of a non-profit plan which is controlled by hospitals, most of which are proprietary, is certainly open to question.

In some plans the question of the acceptance or non-acceptance of hospitals which accord osteopaths the use of their facilities has caused difficulties. A number of plans accept osteopathic hospitals; many plans do not.

In sum, how far the plans should go in endeavoring to assure good quality of service to their subscribers is a moot question. Many plan directors feel that the plans must accept hospitals as they are and that it should be the responsibility of the general community to see that unworthy institutions do not exist. In practice the interest of the plans in seeing that their subscribers receive hospital care of good quality frequently leads to an interest in hospital licensing legislation, and a number of plans have played leading roles in securing the passage of such legislation.

As of October 1, 1944, there were 2,933 hospitals in the United States with a total of 306,871 beds, which were member hospitals of Blue Cross plans. Of the total number of beds all but 35,000 were in non-governmental hospitals. The bed capacity of Blue Cross member hospitals constituted 72 percent of the total number of beds in all non-governmental hospitals which were registered by the American Medical Association -- 79 percent if beds in non-governmental tuberculosis and mental hospitals and the hospital departments of institutions were excluded. These figures were for the country as a whole and included areas in which Blue Cross plans did not operate and thus had no member hospitals.

PAYMENTS TO MEMBER HOSPITALS

The basis and rates of payments to hospitals are determined by negotiation between the plan and the member hospitals. A wide variety of bases of payment are in use. All parties agree that hospitals should be fairly paid for their services but there is considerable difference of opinion as to the basis of payment which will best achieve this result.

Since 1943 or 1944 the problems of remuneration of hospitals have become more acute. In part this is due to the sheer growth of the plans -- when hospitals derive 40 or 50 percent of their income from the plans, as is the case in some localities, then the rate of remuneration is obviously all important. In good part it has been due to advancing prices and hospital costs. This situation has placed a strain upon the relationships of plans and the hospitals. It has made it difficult to arrive at a fair rate of remuneration, and no sooner is

a rate negotiated than advancing costs make hospitals dissatisfied with it and call for a re-opening of negotiations. In certain areas the hospitals have been quite dissatisfied with the remuneration obtained from the plan, and here and there hospitals have withdrawn from participation. On the other hand the plans complain that some hospitals are demanding excessive remuneration. The development of a mutually satisfactory basis of remuneration is one of the most important problems facing the plans and hospitals at this time.

There are three basic methods of payment in use: flat rate per diem payments uniform for all hospitals or groups of hospitals; payments based on each hospital's regular charges; and per diem payments based on each hospital's costs of operation. Modification and combination of these three basic methods exist.

The methods and rates of payment used by the individual plans, as of December 1, 1946, as shown by a recent study of the Blue Cross Commission, are set forth in Appendix E. Of the 81 plans in the United States, 37 can be classified as paying uniform rates or some variation thereof, 25 pay on a regular charge basis, 6 pay on a cost basis and the remaining 13 plans pay on some combination of these three bases.

A simple flat rate basis is used by 31 plans. Almost all of these make higher per diem payments in short stay cases. Thus the Washington D. C. plan pays \$15.00 for a one day stay, \$20.00 for a two day stay, \$27.00 for a three day stay, with graded payments up to \$91.00 for a 14 day stay and a straight \$6.50 per day for all cases lasting 15 days or more. The Alabama plan pays \$10.00 for a one day stay and \$8.00 a day for all cases lasting two days or more. The reason for the higher payments in short stay cases is to reimburse the hospital for the costs of the special services which constitute a large part of the bill in these cases.

A few plans paying flat rates group their hospitals and pay different flat rates to each group. Thus the Colorado plan has a basic rate of \$6.75 per day but pays a few rural hospitals \$6.25 a day. The Rochester plan classifies its hospitals into three groups according to the scope of their facilities and the services provided. The Rochester hospitals are paid \$8.50 per day, and the hospitals outside Rochester are paid \$7.75 or \$7.25 a day.

A few plans (4) which give the subscriber a dollar room allowance pay the hospital the same amount on account of room and board and then pay according to a fixed schedule for the special services.

Of the 25 plans which pay on a regular charge basis, only a few (7) pay 100 percent of regular charges without qualification or modification. An additional two plans pay 97 and 98 percent of charges, respectively. Another two plans pay 90 percent of charges currently, and then at periodic intervals these payments are adjusted to 100 percent of charges, if and to the extent that the finances of the plan permit. Some six plans pay regular charges or a percent thereof, but with a fixed ceiling. In some plans this ceiling operates for the individual case; in others on the average of all cases over a period. (It is hard to know whether to classify these plans as paying flat rates or regular charges.) Four plans pay regular charges or a percent thereof but with a ceiling on the room charge and another four give a dollar room allowance and pay regular charges only for the special services.

The plans which pay regular charges ask the hospitals to submit a schedule of their regular charges, and these plans then check the bills of the hospital against the schedule. At the time of the survey some of the plans paying regular charges would permit increases in these charges only on six

months' notice. One plan which did this would refuse to approve increases in a hospital's charges if it deemed the proposed rates out of line with those of comparable hospitals. How successful these plans have been in maintaining this control through the past year or two of mounting hospital charges is not known.

Per diem costs of operation, generally subject to certain maximum and minimum limits, are paid by six plans.

Of the 13 plans paying on some combination of the above bases a few pay flat rates which are subsequently adjusted "up" to average regular charges or a percent thereof. In the case of three plans this latter adjustment is made if and to the extent that the finances of the plan permit. Two plans pay flat rates or charges, whichever are the lower, three pay costs or charges whichever are the lower, another pays regular charges in surgical cases and a flat rate per diem amount in medical cases.

ADVANTAGES AND DISADVANTAGES OF THE VARIOUS METHODS OF PAYMENT

All of the present methods have their advantages and their drawbacks. One method may work best at one stage of a plan's development, another method at another stage.

The flat rate method of payment was the one generally used by the early plans. It has many advantages. It is simple and time conserving both for the hospitals and the plan. It has a certain justice: all hospitals are paid alike and the more efficiently conducted hospital will be able, with a given payment, to provide a superior grade of service. Perhaps this method of payment would be more equitable if hospitals were grouped according to their facilities or services and appropriate payments made to each group.

A disadvantage of this method of payment is that in terms of their regular billings or charges, some hospitals appear to be "overpaid" and others "underpaid". In many plans with this method of payment one finds payments to some hospitals running 10 to 15 percent in excess of their regular charges, while payments to other hospitals fall short of regular charges to a corresponding extent. This situation is especially apt to exist in the case of state-wide plans with member hospitals ranging from the elaborate city institution to the simple rural hospital.

It is difficult for a plan to justify to itself, the public and other hospitals, payments to some hospitals in excess of what these hospitals would collect from the same patients if they were not members of the plan. (Yet such payments may help a struggling hospital to improve its services.) Equally, if not more serious, is the apparent "underpayment" of some hospitals. An "underpayment" of, say, 10 percent may not be serious for a hospital if only 10 percent of the hospital's patients are plan members, but when 40 or 50 percent of the hospital's patients are plan members such an "underpayment" becomes quite serious.

It is this situation which has caused more and more plans to shift from the uniform rate method of payment to one which takes account of regular charges.

The method of paying hospitals according to their regular charges avoids the above problem. It is designed to give hospitals the same income from plan patients as they secure from non-plan paying patients, and in this there is a certain justice. However, this method of payment also has important disadvantages.

In the first place the established charges of a hospital are presumably determined so as to give the hospital the income it needs, taking account of the fact that some collection losses are incurred and that a certain volume of free work is performed. However, there are no collection losses for Blue Cross patients, and a certain proportion of Blue Cross patients would have been charity cases were they not members of the plan. Hence it would seem that something less than 100 percent of regular charges would represent fair payment.^{2/}

In the second place a hospital's regular charges may bear no close relation to its costs of operation nor to the quality and scope of service rendered. The regular charges of some hospitals rendering an inferior service may be higher than those of the better hospitals of the area.^{3/} In the case of proprietary hospitals, to pay regular charges would appear questionable. In a sense payment of regular charges, when these are subject to no control by the plan, is a unilateral arrangement -- it is not a rate determined by negotiation between the two parties -- and there is some reason to believe that ultimately it may result in the plan going onto a dollar allowance basis in self protection.

Another disadvantage of the regular charge method is that it is cumbersome and costly from an administrative standpoint. Each hospital bill must be checked over to see that the charges are in accordance with the hospital's schedule of charges. It is time consuming to do this accurately. (A hospital's schedule of charges, including charges for all the different x-ray and laboratory services and drugs, may run to over a dozen pages.) The Cincinnati plan has five or six employees who do nothing else but check hospital bills. The costs of this process runs into sizable amounts of money, and if the plan could save these amounts, it, the subscribers and the hospitals would in the end be better off.

^{2/} The following comments by Dr. Peter D. Ward are pertinent in this regard. In reporting upon a meeting between Trustees of the American Hospital Association, of which he was then president, and Blue Cross representatives, he wrote:

"This is all by way of saying that the trustees were greatly impressed by the comments of one of the plan directors regarding the standard of effectiveness which is being generally employed by hospitals - the comparison of total receipts from Blue Cross subscriber patients against total billings for the care of such patients. The spokesman for the plans pointed out what each of the hospital administrators present agreed was the truth, that average per diem receipts had been greatly increased by Blue Cross.

What are the troubles then? They appear to rest first upon the general adoption of the idea by hospital administrators that total receipts of anything less than total billings represent this much loss to the hospital -- even though this loss over the whole of a Blue Cross plan's experience may not be more than 7 or 8 percent, and in spite of the great gain which hospitals have achieved through Blue Cross in the encouraged use of higher priced facilities, in the diminishing of free cases, in the lessening of collection losses and the greatly expanded volume resulting from Blue Cross.

The long term interests of hospitals now require that we judge Blue Cross not upon a comparison of total receipts and total billings but upon the comparison of receipts from Blue Cross subscriber patients and the receipts from all other paying patients including those who use pay ward facilities. The accounting practice which certain hospitals regularly follow -- that of obtaining board approval month by month to wipe out Blue Cross losses -- cannot but serve to embarrass Blue Cross plans and create further misunderstandings. Boards of trustees of hospitals should be shown the advantages of the Blue Cross income as well as the billing losses." (Hospitals, August, 1946 p. 12)

^{3/} The Massachusetts plan in paying regular charges found that on the average it was paying more per diem to hospitals not approved by the American College of Surgeons than to those approved. To correct this it has placed ceilings on the room charge, one ceiling for hospitals approved for residencies and training of internes, a lower ceiling for other hospitals approved by the American College of Surgeons and a still lower ceiling for other hospitals.



Perhaps the most important disadvantage of the regular charge method, at least when charges are uncontrolled, i.e., where there is no ceiling and hospitals are free to change their charges at will, is that the plan does not have a fixed per diem cost for hospital care. The plans base their subscription rates which they cannot easily or frequently change on the calculation that they will need to provide so many days of hospital care per thousand subscribers per year, at a cost of so much per day of care. If they pay their hospitals on a regular charge basis and hospitals are free to advance their charges at will, the plan may find its calculations upset by an advance in its per diem costs of care. This has been especially serious during the past two years of rapidly advancing hospital costs and charges. Many plans paying uncontrolled regular charges have found themselves in financial "hot water", costs exceeding income and reserves dwindling. It has been this situation, i. e., the need of stabilizing their hospital costs, which has been partly responsible for causing many plans to shift to a dollar room allowance basis.

Remuneration of hospitals on a cost basis, i. e., per diem costs of operation plus an allowance for depreciation of plant, would seem to have many advantages. Hospital costs of operation are definite and can be ascertained. Payment on this basis reduces the element of bargaining which must inevitably enter in when hospitals are paid on a flat rate basis. Since costs are the main basis of hospital charges, it would seem desirable to resort directly to this basis.

There are however several obstacles or drawbacks to payment on a cost basis. One is that while the over-all per diem cost can be ascertained, it may not be possible accurately to calculate the cost of furnishing semi-private care, or of ward care, as the case may be. Again use of a cost basis would be feasible if the plan provides complete hospital service, but there are difficulties when the plan's contract does not cover certain services such as x-rays which may enter into the calculation of over-all per diem costs.

In some localities costs would not be acceptable to the hospitals, at least at present, because of the factor of charity care. Where hospitals are called upon to render large amounts of care to charity patients, and where they receive no remuneration for this care from government or from community agencies, or where the remuneration provided is less than the cost of furnishing the care, then obviously hospitals, in order to finance this free care, must charge paying patients more than the cost of the service provided them. Until and unless hospitals are paid cost for care provided to the indigent, they may not find it feasible to accept remuneration on a cost basis from the plans.

A more fundamental drawback of the cost basis is that it might tend to subsidize inefficiency. If two hospitals in a given locality are providing the same quality and scope of service, but one has costs 10 percent higher than the other, why should the plan pay one more than the other? Certainly under a situation in which all or the vast majority of hospital patients were plan patients it would hardly be possible to utilize costs alone as a basis of remuneration. Hospitals would then not have strong incentives to keep costs down. Almost assuredly it would be necessary to impose a ceiling beyond which costs would not be met. However, the same ceiling for all hospitals would tend to bring down the level of care in the better hospitals and would encourage rural and small town hospitals needlessly to expand the scope of their services. Almost certainly different ceilings varying with the size

and type of hospitals and the scope of service they were prepared to offer would be necessary.

Sooner or later it would seem, the factors of quality and efficiency will need to be brought into the formula of payment. It would seem that hospitals would have to be graded, in one way or another, as to the quality and scope of the service they render, and standards established as to the necessary cost of providing care of a given quality and scope.^{4/}

PRINCIPLES GOVERNING THE RELATIONSHIP BETWEEN HOSPITALS AND BLUE CROSS PLANS ADOPTED BY THE AMERICAN HOSPITAL ASSOCIATION

In October 1946 the House of Delegates of the American Hospital Association adopted certain principles governing the relationships between hospitals and the Blue Cross plans, which had been formulated by the Council on Administrative Practice with representatives of the plans participating. These principles, necessarily couched in broad terms, will probably serve as guide posts to hospitals and the plans in their dealings with one another for some time to come. The salient points of the principles are as follows:

(a) "Hospitals should not expect to receive rates of payment from Blue Cross plans for basic services provided to subscribers in excess of the cost of such services, cost to include an allowance for depreciation of buildings and equipment and allowances for other contingencies..." nor in excess of "100 percent of the average gross earnings at established rates for all private patients occupying similar accommodations in the hospital."

(b) The basis and rates of payment should in all cases be negotiated between representatives of the plan and representatives of the hospitals, both groups having at hand the facts (financial and service data) necessary for enlightened decisions.

(c) Both groups, as public service agencies, should bear in mind the needs of the other.

These principles are quoted in full in Appendix F.

RELATIONSHIP OF PLAN PAYMENTS TO REGULAR CHARGES OF HOSPITALS

In appraising the adequacy or fairness of the payments made to hospitals it would be useful to know the relationship of these payments (plus the payments made directly by subscribers for items of service not covered by the plan) to (a) the hospital's costs of operation, (b) the average per diem income received from all pay and part pay patients and (c) the average per diem income which would be received by the hospital in plan cases, if its regular charges were paid in full. Data of the first two sorts are not available, or at any rate have not been obtained from any plan. Data on the relationship of income from plan patients to the regular charges of hospitals have been obtained from a sample of the plans, and are presented in Table 7.

^{4/} In one city the average per diem charges made to the plan by the hospitals (including maternity and children's hospitals) ranged as follows: x-ray service, \$.25 to \$.88; laboratory service, \$.11 to \$.86; drugs and dressings \$.24 to \$.62; use of operating and delivery rooms, \$.68 to \$1.34. One wonders if these charges accurately reflect costs, and if so, assuming that the hospitals used similar cost accounting procedures, whether the costs reflect quality and adequacy of service.

TABLE 7

Percent of Regular Billings of Hospitals Met by Plan and Subscriber Payments

Data for Certain Plans, 1945-6.^{1/}

PLAN AND PERIOD	PERCENT OF REGULAR BILLINGS MET
A (1946)	A LITTLE BELOW 90 ^{2/}
B (1946)	ABOUT 80 (ABOUT 90 PRIOR TO 1946) ^{3/}
C (1945)	91.9
D (1946)	85 ^{4/}
E (1946)	90 - FOR LARGER HOSPITALS: LESS FOR SMALLER ONES
F (1945)	92.4
G (1946)	FROM 92 IN JANUARY TO 85 IN DECEMBER
H (1946)	ABOUT 95
I (1946)	92
J (1946)	ABOUT 97
K (1946)	94.3 (WILL PAY ADDITIONAL AMOUNTS TO BRING THIS TO 96)
L (1ST HALF 1946)	97 (LESS IN LAST HALF OF YEAR)
M (1946)	95 ^{5/}
N (1ST HALF 1946)	91.6

^{1/} The plans represented here are the following: Los Angeles, Colorado, Delaware, Kansas, Maryland, Michigan, Minnesota, New Jersey, Rochester, New York City, Philadelphia, Wilkes-Barre, Richmond and Roanoke.

^{2/} Revising schedule so that hospitals will average about 95 percent of billings.

^{3/} Revising method of payment so as to pay hospitals their costs.

^{4/} Increased scale of payment in latter part of year.

^{5/} Rate increased in November.

In the case of 14 plans, hospital income from plan patients during part or all of 1946 (in the case of 2 plans during 1945) ranged from 80 to 97 percent of hospital billings at their regular charges. In providing this information a number of the plans, including the four which paid less than 90 percent of charges, indicated that they had recently revised or were in process of revising their rates so as to give hospitals a return closer to regular charges.

The situation during 1946 was unusual in that the rapid advance in hospital costs and charges during this period tended to leave plan payments behind.

HOSPITAL GUARANTEE OF BENEFITS

In most, though not all, Blue Cross plans the member hospitals guarantee the provision of benefits to subscribers and this guarantee forms an important part of the relationship between plans and hospitals. This guarantee of benefits or hospital underwriting of the plan, as it is sometimes called, exists by virtue of provisions in the contract between a plan so underwritten and

its member hospitals whereby the member hospital agrees to provide the contractual benefits to subscribers irrespective of the remuneration received from the plan.

Hospitals undertake this obligation towards the plans because of their sponsorship of the plans and because such an obligation, at least in the case of new plans, is necessary for the protection of the subscribers. The plans, as we have seen, start with very little funds. The hospitals' guarantee of benefits takes the place of the reserve or capital funds which the plan, engaging in an activity which partakes of the nature of insurance, would otherwise need for the protection of its subscribers. This fact is recognized in the enabling acts of 14 States which stipulate that the contracts issued by a hospital service plan shall constitute direct obligations of the member hospitals.

On a number of occasions hospitals have been called upon to make good upon their guarantee of subscriber benefits. Thus the New York City plan was helped out of financial difficulties in 1939 when for a few months its member hospitals accepted a 25 percent reduction in the rates of payment. Here the hospitals did this even, though not bound to do so by the terms of their contract with the plan. During the same year the Massachusetts plan reduced payments to hospitals by 20 percent for a few months. In 1944 the Des Moines plan was forced to cut its payments to hospitals by 25 percent for a few months. There have been other instances. In all cases the action of the hospitals in temporarily accepting a reduction in payment enabled the plan to regain its financial feet and gave it time to adjust its rates and benefits so as to place itself on a sound basis. In all cases the amounts withheld from the hospitals were later repaid in full.^{5/}

With this introduction let us see to what extent the plans are contractually underwritten by their member hospitals. It would appear that a contractual obligation of hospitals to underwrite a plan involves two elements: (a) a definite agreement on the part of the hospitals to provide the contractual services to subscribers whether or not the plan pays hospitals at the rates scheduled in the hospital contract, and (b) a definite obligation on the part of the hospitals to provide such service and to accept reduced payments, if necessary, for a period sufficiently long to give the plan time to adjust its rates, benefits, or hospital payments, so as to regain a sound operating basis. For this latter purpose a period of at least six months' duration would seem to be necessary.^{6/}

^{5/} In five plans (Des Moines, Minnesota, Oklahoma, Wilkes-Barre and Texas) the contract with the hospitals (as of December, 1946) provides for a specified remuneration with additional payments if the finances of the plan permits.

^{6/} Some students of this problem hold that if hospitals agree to accept reduced payments and if the period of notice required for cancellation by the hospital of its contract exceeds the period of notice required for cancellation by the plan of its contract with subscribers, there is hospital underwriting. According to this view, hospital underwriting exists if a plan can cancel its contract with its subscribers on, say, 15 days' notice and member hospitals can cancel their contract with the plan on, say, 30 days' notice. The writer is unable to share this view. A period of 30 days is too short for a plan to put a change in rates into effect. It is true that a plan which was heading for financial difficulties, but which still had an excess of assets over liabilities, could conceivably cancel its contracts with subscribers on, say, 15 or 30 days' notice, and not replace the old with a new contract. However, to do this would mean liquidation of the plan. It would seem that real hospital underwriting exists only if the hospitals agree to back up the plan financially for a period sufficiently long so that the plan can revise its subscriber and hospital contracts and continue as a going concern.

In the case of the plans included in the field survey the provisions relative to hospital underwriting in the plan's contract with the hospitals fall into six main types as follows:

1. The hospitals definitely agree to accept reduced payments if necessary. Hospitals can terminate their contract with the plan only on a year's notice. Or the hospitals can terminate their agreements on six months' notice, but agree to provide service to subscribers for the remainder of each subscriber's contract year.

Here there is very definite and real underwriting. Of 36 plans, for which definite information was obtained, 10 were in this group.^{7/}

2. The hospitals definitely agree to accept reduced payments if necessary, but they can terminate their agreement on short notice, usually one or two months. However, they must provide service to subscribers, as of the termination date, during the remainder of each subscriber's contract year.

These provisions entail hospital underwriting, but to a somewhat less degree than exists under 1 above. Hospitals would have to accept reduced payments for varying periods for various subscribers depending upon the months to run in their contract years.^{8/} Of the 36 plans, 11 were definitely in this category and possibly two others depending on the interpretation of the contract.^{9/}

3. Hospitals agree to accept reduced payments, but can terminate their agreements on 30 or 60 days' notice. They do not agree to provide service after the termination date.

According to the language of the contract, the value of the underwriting obligation here undertaken seems relatively small. It will not help a plan very much if the hospitals will accept reduced payments for only 30 or 60 days, because such a period would be insufficient for the plan to revise its contracts. Two plans have provisions of this type.^{10/}

4. The hospitals do not agree to accept reduced payments. Hospitals can terminate the agreement on short notice but agree to provide service (presumably only if paid at the pre-existing rate) on existing contracts during the remainder of the contract year of each subscriber.

It is difficult to determine from the contracts of these plans whether the plans are underwritten or not. On the whole the plans do not appear to

^{7/} The Delaware, Des Moines, Kansas City, Maryland, Massachusetts, New Orleans, St. Louis, Texas, Richmond, and Roanoke plans. The listing of plans under this and subsequent classifications is on the basis of the provisions of the hospital contract at the time when visited. (March, 1944-February, 1945.) The plans have been listed according to our interpretation of the contracts, which may be at variance with the opinion of the plan personnel or what a court of law would hold.

^{8/} In the case of some plans these underwriting provisions are somewhat out of line with the provisions of the subscriber contracts. Thus, 5 of the 10 plans with this type of agreement can cancel or revise their subscriber contracts on either 15 or 30 days' notice. In practice these plans, if they wished to revise their contracts, would cancel all old contracts at the same time and substitute the revised contract; they would not wait until each subscriber's contract year expired, which would mean staggering the revision over a year's period. It would be better for these plans if their hospitals agreed to accept reduced payments for a six months' period for all subscribers. This would not impose a greater obligation upon the hospitals, but their effective help to the plan would be greater.

^{9/} The Kansas, Rhode Island, New Hampshire, Nebraska, Utica, Oregon, Minnesota, Norfolk, Savannah, Michigan and Washington, and possibly the Philadelphia and Cincinnati plans.

^{10/} Huntington and Maine. However, Maine's enabling act definitely requires that subscriber contracts shall constitute a direct obligation of the hospitals. The new West Virginia law (passed in March 1946) has the same provision. The act which was in effect when the Huntington plan was visited did not have this stipulation.

be underwritten by their hospitals, because if the plan reduces the rate of payment it breaks the contract and hospitals would be relieved of any obligations towards the plan. Two plans are in this group and two others are either in group 2 or this group.^{11/}

5. The hospitals do not agree to accept reduced payments. Hospitals can terminate the agreement only on long notice, i. e., on notice of six months or more.

Such plans do not appear to be underwritten by their hospitals. If the plan lowers the rate of payment, it breaks the contract. Two plans have provisions of this type.^{12/}

6. The hospitals do not agree to accept reduced payments. Hospitals can terminate the agreement on short notice, i. e., usually 30 or 60 days.

Such plans do not appear to be underwritten by their hospitals, for the same reasons as under "5." Of 36 plans 7 were in this group.^{13/}

It will thus be seen that of 36 surveyed plans for which definite information on this point was obtained, 23 plans appear to be definitely and firmly underwritten by their member hospitals. An additional plan is underwritten to some extent, and in one instance it is difficult to decide whether or not there is hospital underwriting. The 11 remaining plans do not appear according to the terms of their contracts to be underwritten by their member hospitals.

Assuming that the surveyed plans can be accepted as representative of all of the plans, it would appear that slightly more than two-thirds of all of the plans are contractually underwritten by their member hospitals, while a little less than one-third of the plans are not so underwritten. However, it should be added that it is the writer's impression that in the case of most of the plans in which hospitals do not guarantee subscriber benefits the hospitals would come to the rescue of the plan if it got into financial difficulties. (This backing, however, might depend upon whether the hospitals thought the plans well managed and upon the extent of aid required.) In other words the hospitals of these plans feel a certain moral obligation toward the plan which would in all probability lead them to back up the plan. The self-interest of hospitals would also impel in the same direction since hospitals could hardly afford to permit the collapse of a plan which had become valuable to them.

SOME OBSERVATIONS RELATIVE TO HOSPITAL UNDERWRITING

It is obvious that guarantee of subscriber benefits by the hospitals is enormously valuable to a new plan. In fact, unless the plan starts with substantial initial funds, it is essential. Otherwise the plan operates upon a "shoe string" and subscribers have no real protection. The enabling acts of the various States uniformly relieve hospital service plans of complying with the requirements as regards capital or reserves which are imposed upon insurance companies. It would seem that the plans could safely be relieved of these requirements only if they are underwritten by the hospitals.

^{11/} Chapel Hill and New Jersey. The Cincinnati and Philadelphia plans are either in group 2 or this group. However, inasmuch as the Ohio law stipulates that hospitals must assume responsibility for the provision of benefits to subscribers, it would seem that the Cincinnati plan can be regarded as definitely underwritten by its member hospitals.

^{12/} Rochester and Wilkes-Barre.

^{13/} Sacramento, Colorado, Durham, Los Angeles, New York City, Oakland, and Rockford.

In the case of a mature plan which has accumulated substantial reserves it is not necessary for the protection of subscriber benefits. However, such guarantee is advantageous in many ways. It enables the plan safely to operate with smaller reserves than would otherwise be necessary and thus currently to provide more generous benefits to subscribers. It is an added protection to the subscribers. It ties the hospitals and the plan together and gives the hospitals a direct interest in the plan and its welfare. It is evidence to the public of the real backing and cooperation of the participating hospitals.

In this connection, however, it should be recognized that as a plan matures and develops a substantial reserve the underwriting burden is shared between the public, which has contributed the plan's reserve, and the hospitals. Further as a plan enrolls a larger and larger proportion of the population of its area, the ability of hospitals to make good on any guarantee of subscriber benefits becomes qualified. When only, say, 5 percent of the population of the area is enrolled it is entirely possible for the hospitals to accept a reduction of payments of, say, 25 percent for six months or a year. But if 60 or 75 percent of the population were enrolled, it would be difficult if not impossible for the hospitals to accept such a reduction for even a short period of time. Under these conditions it would seem that more and more of the underwriting burden must be assumed by the subscribing public, i. e., through the plan having an adequate reserve.^{14/}

In recent years hospital underwriting has received less emphasis in the thinking of the leaders of the movement. In part this is due to the fact that most of the plans have developed substantial reserves and that these plans tend to look for their security to their reserves rather than to the hospitals. In other words most plans are run so as to avoid recourse to the need for hospitals to make good on their guarantee. The hospitals of some areas have indicated a desire to be free from the underwriting obligation and in at least one case (Washington, D. C.) the underwriting provision has been removed from a plan's contract with its hospitals.

The guarantee of benefits by a plan's member hospitals carries important implications as regards the nature of the plan and its control. A plan which looks entirely to its member hospitals for its security, which has no reserves of its own, tends to be an agent of its member hospitals. It becomes independent, so to speak, only as it achieves some measure of financial independence. Obviously hospitals have much stronger claim to dominant control of a plan when they guarantee the plan's benefits than when they do not.

^{14/} As an indication of the thinking of some leaders in this field may be cited the following remarks by Dr. Ward (see footnote 2 this chapter):

"The second general problem for all hospitals, as well as plans, is the varying degree of financial responsibility of Blue Cross plans across the country and a lessening confidence which develops when hospitals cancel contracts. It was apparent to me on the basis of this discussion that full confidence in Blue Cross nationally by all hospitals will never be achieved until every Blue Cross plan is as interested in the standing of every other plan as in its own. This probably means that the plans will have to develop a reinsurance fund administered by themselves.

"Under such a proposal, as it has been roughly sketched out, each Blue Cross plan would pledge certain assets into a general fund which could be drawn upon in the case of financial failure by any Blue Cross plan.

"The service contract of hospitals, important as it was at the beginning of Blue Cross, and still may be as evidence of the good faith of participating hospitals, can no longer be regarded as sufficient guaranty to either public or hospitals. In some areas Blue Cross now accounts for about 50 percent of entire hospital income. The risk of failure is too great to be borne with any degree of assurance. A possible debt greater than the debtor can bear is not a sound basis for extending credit nor a keystone to be used in the development of a voluntary health insurance system." (Hospitals, August 1946, p. 12.)

CHAPTER 6

ENROLLMENT POLICIES AND PROCEDURES

The enrollment methods of Blue Cross plans are designed to secure the largest possible enrollment at the least possible expense and to assure actuarial soundness. The last consideration dictates that either enrollment should be through groups, with a sufficient percentage of the members of each group joining so as to assure that those enrolled will comprise a fair selection of risks, or that enrollment of persons on an individual basis should be conducted under methods which will avoid adverse selection of risks.

GROUP ENROLLMENT

The main method of enrollment is through groups of employed persons at their place of employment. To guard against adverse selection of risks minimums are set as to the size of groups which will be accepted and the percentage of the members of the group who must enroll. Some plans accept groups of two or three persons; many of the plans do not ordinarily accept groups of less than five persons; a few accept only groups of 10 or more. The general trend is for the plans to accept smaller and smaller groups.

The minimum percentage of the members of a group who must enroll if the group is to be accepted varies with the size of the group. Commonly the plans require one hundred percent enrollment in groups of 10 or less, ninety to fifty percent among groups of 10 to twenty-five, the percentage decreasing progressively as the size of the group increases, and forty or fifty percent among groups of twenty-five or more.

The first step in enrollment of an employed group is to persuade the employer to make the plan available to his employees. By making the plan available to his employees is meant that the employer provides an opportunity for explanation of the plan to employees and agrees to set up an arrangement for collection of the subscription charges.

The next step is to explain the plan to the employees. This is done partly through the distribution of literature. However, some mode of oral presentation, either in group meetings or individually, is generally essential. Group meetings involve a stoppage of work for the time being and are sometimes difficult to arrange in noisy factories. They have the disadvantage that oftentimes individuals are reluctant to ask more or less personal questions before a group. A method used by many of the plans is that of individual solicitation. On the day or days of the enrollment campaign, enrollment representatives are stationed throughout the plant and interview each employee individually. With good endorsement of the plan by the employer, the union, or both and proper presentation to the employees a 75 percent or higher "sign-up" is common.

The plans differ in the extent to which they let the employer assume responsibility for the enrollment effort. A few ask the employer to assume

the major burden of presentation and achieve good results. Others prefer to conduct their own solicitation campaign among the employees.

Often unions play a decisive role in the enrollment of a group. The employees through their union may request the employer to make the plan available to them. Frequently, then, the union will sponsor presentation of the plan to the individual employees.

After a group is enrolled, arrangements must be made for subsequent enrollment of new employees and of those who had not joined previously. In the case of small groups the opportunity of enrollment is made available to new and old employees through group re-openings, customarily held once or twice a year. On such re-openings, very much the same procedures are gone through as in the original solicitation.

In the case of large firms, the plans customarily have different procedures for enrollment of new employees and of old employees who had previously not joined. Usually new employees will be given the opportunity of enrolling when they are first employed, their applications to become effective immediately or in a month or two. (The reason for holding such applications for a month or more before making them effective is to avoid the expense of enrolling "floaters", and to avoid any adverse selection due to persons taking employment with a concern for a short period solely to obtain hospital protection; this last may be important when a plan waives its customary restrictions on care for maternity and preexisting conditions.) Old employees who have not previously joined are given the opportunity of enrolling at group re-openings held semi-annually or annually. The reason for not permitting employees, who had previously not joined, to enroll whenever they desire is to avoid acceptance of a disproportionate number of persons who have an immediate need for hospital care.

The technique of group enrollment can be used for many types of groups other than those composed of employees working for a common employer. Many plans have enrolled physicians, dentists, nurses, lawyers, school teachers, and similar groups through their professional associations. Such persons are enrolled on a group basis but usually pay the subscription charges directly to the plan on an annual, semi-annual or quarterly basis. A number of plans have enrolled independent grocers, lumber dealers, and other retail and wholesale dealers through their associations on the same basis. Some plans have enrolled building trade workers, taxicab drivers and similar groups of workers who do not work regularly for any single employer, through their unions. The workers pay the subscription charges along with their union dues or directly to the plan. As will be related in more detail later, members of local Farm Bureau, Grange, and Farmers' Union groups and of farm cooperatives have been enrolled on the same basis, the enrolled members either paying directly or through the organization.

All plans permit persons leaving the group through which they enrolled to continue membership by paying the plan directly.

PAYMENT OF SUBSCRIPTION CHARGES

Subscription charges are paid through three methods: payroll deduction, a group treasurer arrangement, or direct payment.

Payroll deduction is the usual method for employed groups. Here the employer deducts the subscription charges from the pay due the employee and remits the total to the plan. The plan facilitates this by sending the employ-

er each month a list of the enrolled members with the amounts due from each. The advantages of payroll deduction for the plan are that the burden of collecting the subscription charges is assumed by the employer, the collection of charges will in general be performed accurately and promptly, the chances of members not paying through forgetfulness or temporary absence are removed, and the continuation of membership is more or less automatic. In other words, having once given the authorization for the deduction, the employee does not have to make a positive decision each month as to whether he shall continue his membership. He is thus more likely to continue.

The group treasurer system can be used both for employed and other types of groups. Under this system the employer or the members of the group selects one individual to be responsible for collecting the monthly subscription charges and forwarding them to the plan. In the case of an employed group, the group treasurer makes the collections on company time, but this is usually the extent of company responsibility for the arrangement. The group treasurer receives no compensation from the plan and performs his duties simply as a service to the other members of the group.

As compared with payroll deduction the group treasurer system has several disadvantages. The group treasurer may leave the company or the group and another individual must be found to take his place. Individuals forget to pay the group treasurer, or they do not have the money or are absent at the time the charges are due. The member must dig down into his pocket each time, and this raises in his mind the question of whether the protection is worthwhile and should be continued.

Because of the great advantages of payroll deduction, many plans have adopted the fixed policy of not accepting an employed group unless the employer will agree to payroll deduction, if it is legally possible. Federal agencies are prohibited from making deductions from the pay of Federal employees, and some State and local governments have similar prohibitions.

Under direct payment, the subscriber pays the plan directly, either by mail or over the counter, usually on a quarterly, semi-annual or annual basis. In most plans the main classification of members paying directly are the so-called group conversion subscribers -- those who originally enrolled with an employed group but have left this place of employment. Persons enrolled through groups other than employed groups, members of very small employed groups, and persons enrolled on an individual basis usually pay the plan directly.

In order to encourage all direct payment subscribers to transfer to groups when they can, a good many of the plans have slightly higher rates for these subscribers.

INDIVIDUAL AND COMMUNITY ENROLLMENT

Within the last few years the Blue Cross plans have given increasing attention to enrollment of individuals other than through groups at the place of employment. The plans recognize that their social purposes and public relations require that the opportunity of enrollment should be available to all members of the population.

In 1937 and 1938 a number of plans made enrollment available to individuals. Applications were accepted by mail or over the counter, and these persons were issued the same contract as group subscribers. The results were unhappy. A disproportionate number of persons enrolled who knew they needed

hospitalization or who were planning to have a baby. In the case of the New York City plan which accepted substantial numbers of such subscribers, the rate of hospital utilization among these subscribers was so great as to jeopardize the plan's financial position, and approximately 100,000 of these subscribers had to be cancelled out.^{1/} These experiences demonstrated that enrollment of individuals was dangerous unless conducted under methods which would avoid adverse selection of risks.

At the present time most of the plans have arrangements through which individuals can join at one time or another on a non-group basis. Some do this through so-called permanent direct enrollment programs wherein individuals are accepted at any time; others conduct community enrollment campaigns wherein enrollment is thrown open to individuals for a limited period of time. Some plans have both types of enrollment programs.

At the time of the survey about a quarter of the surveyed plans had permanent direct enrollment programs. The number of plans with such programs has been constantly increasing. Most of the plans with this type of enrollment require the applicant to fill out a detailed health history statement. These applications are then carefully screened and applications from persons whose health history indicates that they may be poor risks are rejected. A few of these plans accept applicants only after a physical examination.

Most of the plans accepting individuals on this basis charge a higher rate to them than to group enrollees; all exclude preexisting conditions from the coverage offered these subscribers; about half exclude maternity care; and several provide a contract which is restricted in other respects as compared with that offered group subscribers. Almost all of the plans accepting individuals on this basis refuse persons over 65 years of age.

Few of the plans accepting individuals on this basis have enrolled any large number of them. The need of guarding against adverse selection compels restrictions and procedures which are costly and not susceptible to use on a mass basis.

Mass enrollment of individuals through community enrollment offers larger possibilities of reaching people who cannot be reached through group enrollment. This type of enrollment was first undertaken by the Minnesota plan in 1938 and 1939. At the present time a large majority of all of the plans are doing some community enrollment, and other plans are fast adopting the idea.

In community enrollment an enrollment drive lasting anywhere from a week to a month is put on in a particular community. During this campaign enrollment is offered to those who work in groups on a group basis and to individuals on an individual basis. All possible use is made of publicity, community civic groups, and civic spirit. At the end of the drive enrollment on an individual basis is closed until the next campaign which may be held six months or a year later.

While the techniques of these community enrollment drives vary from plan to plan and with the size of the community, the essential principle is the same. An intensive effort of limited duration is made to inform the whole community about Blue Cross. Success is obtained by using some of the tech-

^{1/} For a period the plan accepted so-called self-formed groups, i. e., a person who wanted to join would get a specified number of others to agree to join and all would be accepted as a group. It is understood that a good part of the plan's difficulties came from this type of enrollment.

niques of a "Community Chest Drive". The first requisite of success is full and enthusiastic support by the hospital or hospitals and the medical profession. The next is ample publicity obtained through all possible devices, including paid advertising. The third is some central place where individuals may enroll and the utilization of teams of enrollment representatives to call on employers.

In small communities some of the plans get a local organization -- the women's club, the Red Cross, etc. -- to sponsor and carry on the drive. This organization appoints a committee to head the effort. The town may be split into sections and a leader in each section canvasses the families and enrolls them. The key to successful community enrollment is presentation of the plan as a community service and utilization of all community sponsorship and aid. Plans report that in well-organized community enrollments in small places, fifty percent or more of the population is frequently enrolled.

An average selection of risks tends to be assured under community enrollment because of the limited period during which individual enrollment is permitted. In other words, people join at the time set by the plan and not when they learn of some condition requiring hospital care. In small communities where intensive drives are undertaken sound selection of risks is also assured because as high a proportion of the whole community enrolls as would be considered necessary in the case of an employed group. Indeed some plans will not undertake a community enrollment except with the understanding that their usual group requirements will be met, i. e., unless 40 or 50 percent of the eligible residents sign up.

A great many of the plans are conducting variations of community enrollment drives in large cities. The Rhode Island plan has conducted several state-wide campaigns, making extensive use of paid advertising. The New York City plan on several occasions during the last three years has appointed two or three week periods during which individuals could enroll without the necessity of filling out a health history statement. Paid newspaper advertising was used to announce this opportunity. Many other plans have done or are doing likewise. The plans are finding that such campaigns give marked stimulus to group enrollment, and that often far more people are enrolled in groups during the period than are enrolled as individuals.

It would appear that through the device of community enrollment, or, if one prefers, of individual enrollment limited to specific periods of time, the plans have found a way of cheaply and soundly making their services available to individuals not eligible for group enrollment.

RURAL ENROLLMENT

Within the last few years the plans have given increasing attention to rural enrollment. According to a recent survey of the Blue Cross Commission well over half of the plans are now making some efforts to enroll farm and rural people.

The method of rural enrollment used most generally, or at any rate that which has resulted thus far in the greatest number of subscribers, is community enrollment. The method next most generally used is that of enrollment through organizations such as the Farm Bureau, Grange, Farmers Union, farm cooperatives, etc. These organizations facilitate enrollment of their members, and the enrolled members pay the subscription costs either directly or through the organization. State Farm Bureau Federations in Texas, Minnesota, Missouri, Nebraska and other States have assigned special workers to promote enrollment

of their members in the plans. In a number of States the plans have enrolled farm families who are borrowers from the Farmers Home Administration (formerly Farm Security Administration) through cooperative arrangements with the latter. The FHA enrolls as a group its client families who wish to participate and pays the subscription charges on their behalf. The families repay these costs along with other loans.

Enrollment through the above organizations is necessarily limited to the members of these organizations. The Colorado and Des Moines (Iowa) plans, particularly the latter, have launched a program of developing county rural health associations to make enrollment available to all farm families. The purpose of these associations, which are usually organized with the cooperation of local farm groups, is to promote general health activities and to enroll their members as a group in the plan. The members pay annual dues of, say, \$1.00 an adult person and these go to pay the expenses of the association and to provide some remuneration to a secretary-treasurer. The organization sets up procedures for enrollment of farm families and for collection of the subscription charges. In Iowa 52 county "Health Improvement Associations" have been organized in rural counties, during the last two years. Through these associations over 50,000 rural Iowans have thus far (April 1946) been enrolled.

In reporting on rural enrollment to the Blue Cross Commission as of July 1946 some 53 plans in the United States estimated that they had enrolled 1,480,000 rural persons.² Of these, 17 plans reported that members of their rural enrollment groups numbered over 10 percent of the rural population of their areas. While these estimates are of necessity rather rough and while some of the figures may be exaggerated, nevertheless they indicate that in certain areas serious efforts at rural enrollment are being made and that promising enrollment techniques have been developed.

AGE RESTRICTIONS

Age restrictions are an enrollment policy which may appropriately be commented on here. Of the 81 plans in the United States (data as of December 1, 1946) 52 have no basic age limit for group enrollment, although some of these apply an age restriction for special types of members, as for example sponsored dependents and for community enrollment.³ The remaining 29 plans apply an age limit for original group enrollment -- 65 years of age in the case of 26 plans, 66 years in 2 plans and 70 years in one plan. Four plans do not permit membership to be continued beyond an age limit -- 65 in all four cases. As indicated previously, almost all (34 out of 40 U. S. plans for which data are available) apply an age limit for non-group enrollment, usually 65 years.

The purpose of these age restrictions is to guard against adverse selection of risks; persons 65 and over have a hospital utilization rate approximately double that for persons of all ages.

²/ Special Study No. 84; Survey on Blue Cross Rural Enrollment.

³/ Data from Blue Cross Commission, *Adult Age Limits Applied by Blue Cross Plans, Special Study No. 85, December 1, 1946.*

COMPETITION WITH INSURANCE COMPANIES

There is keen competition between the Blue Cross plans and insurance companies. Appendix K describes the policies offered by these companies and their methods of operation. Thus far the Blue Cross plans appear to be in the lead in this competition in that they have by far the larger total enrollment and are growing more rapidly.

The competition between the Blue Cross plans and insurance companies doing a group business is especially keen in the case of large national concerns, concerns with plants or offices in different localities and states. Insurance companies have an advantage in the case of these concerns which does not exist in the case of local concerns in that the insurance company can provide the concern with a single policy which at a uniform rate gives uniform dollar benefits to all employees wherever they may be located. The need of meeting this competition is driving the Blue Cross plans toward closer coordination, as will be brought out later.

EMPLOYER PARTICIPATION

Since 1943 employer participation in paying part or all of the subscription costs has become an important factor in enrollment.

It has always been more or less customary for employers to pay part of the cost of group life and disability insurance for their employees. Employer participation in paying the cost of hospital and medical protection is simply a projection of the same development in these other fields and proceeds, in general, from the same motives. In other words, employers find that this protection is beneficial to the employees and they find it worthwhile to encourage it or make it possible by paying part of the cost.

Employer participation in paying the cost of hospital and medical protection, as with other forms of group insurance, was stimulated during the war by excess profits taxation and by the freezing of wage rates. By paying part or all of the cost of group insurance employers could give a small wage increase to their employees at very little net cost to themselves. While these factors have now disappeared, the plans report no diminution in the extent of employer participation, on the contrary a steady growth.

A recent study by the Blue Cross Commission of the extent of employer participation found that as of December 1946, employers were paying part or all of the subscription costs for 1,530,000 persons in this country, 7.3 percent of the total membership.^{4/} Since enrollment in employed groups probably does not constitute more than 80 percent of the total enrollment, on the average, it may be calculated that employers were contributing to the costs of membership for about nine percent of their employees and the latter's dependents.

The proportion of the total membership paid for, in whole or in part, by employers varied from zero in one plan to 72 percent in the case of the Kingsport (Tenn.) plan, (82 percent in the case of the British Columbia plan). The proportion of contributory to total enrollment was highest in the New England and Pacific Coast States and was considerably higher (12 percent) in Canada than in this country. The percent of contributory membership was greatest

^{4/} Blue Cross Commission, *Employer Participation in Cost of Blue Cross Membership, Special Study No. 92*, February 27, 1947. The data are based on reports from 77 plans with 92 percent of the total membership.

(15.1 percent) among plans with 50,000 to 100,000 members, and least (5.6 percent) among the largest plans, those with 500,000 or more members. There seemed to be little correlation between percent of area population enrolled and percent of contributory membership. Some of the plans with the highest percentage of the area population enrolled reported very few contributory members.

Of the 11,782 firms reported as meeting part of the cost of membership 83.2 percent paid at least the full cost of membership for the employee; 37.9 percent paid the full cost for both the employee and family members, and an additional 9.9 percent made a partial payment toward the cost of membership for the family.

Special data are available for the Rhode Island plan which, after the Kingsport, Tenn. plan, leads in extent of employer participation. As of December 31, 1946 this plan had 446,128 subscribers of whom 319,600 were enrolled on a group basis through the place of employment. This plan has a "comprehensive" contract which it makes available to groups of over 25 employees where at least 90 percent of the employees enroll. This contract is rarely sold without employer contributions. Of the total group enrollment 60 percent were covered under the "comprehensive" contract, from which it may be assumed that employers were paying for almost this proportion of the total enrollment in employed groups. The plan estimates that employers were contributing 71 percent of the total annual income from the "comprehensive" groups and 38 percent of the total income from all groups. The plan's director believes that the high extent of employer participation is due largely to the plan's comprehensive contract which, since it offers greater benefits at lower cost than the standard contract, provides an inducement to employers to enter into the program.

Employer participation is important to the plans not only because it increases membership by making the plan available to persons who could otherwise not afford to join but because it improves selection: with employer participation virtually 100 percent participation is obtained. Employer participation is especially important in the sale of medical plan coverage. Many plans report that whereas there is little sales resistance at present to hospital service protection, there is appreciable sales resistance (this may lessen with greater familiarity) to the combined hospital and medical coverage at double the cost. Some plans report that they make little effort to sell the combined coverage without employer participation. (On the other hand, other plans report ready sale of the combined coverage without this aid.) In any case it may be assumed that a survey of employer participation in the case of medical plans would show a far greater extent of such participation.

BLUE CROSS PROTECTION ESTABLISHED THROUGH COLLECTIVE BARGAINING AGREEMENTS

In a great many instances, as has been previously indicated, the employees of a concern through their union have requested or demanded that the employer make Blue Cross protection available to them. Since 1943 unions have manifested increasing interest in arriving at agreements with their employers whereby hospital protection or other health benefits will be made available to their members, with the employer paying part or all of the cost. According to a recent study approximately 1,250,000 workers were employed early in 1947 under such agreements, this being double the number covered two

years earlier.^{5/} Probably not more than 40 percent or half of these workers are covered under agreements providing for hospital protection.

Some of these agreements apply to a single concern, others cover an entire industry. In most cases the program is financed entirely by the employer who frequently pays a definite percentage of his payroll, usually two or three percent.

Under some of these plans the employer agrees to make certain benefits available, and in the case of hospital protection, such protection is made available by the employer through Blue Cross or a commercial company. Under other agreements the employer's contribution goes into a fund which is administered either jointly or by the union alone, and this fund pays the cost of group insurance, including hospital protection, for the members of the union. Hospital protection may be provided either through Blue Cross or a commercial company or through a plan especially set up by the fund or the union.

The specification of Blue Cross protection under employer-union agreements has made special headway in the New York City area. Between September, 1944 and September, 1945, benefits of the Associated Hospital Service of New York were specified in more than 340 collective bargaining agreements of 31 AFL and CIO national and local unions. These agreements, it is reported, cover more than 175,000 employees and dependents. In 75 percent of the contracts the employer pays the entire cost.

The development of union health and welfare programs may well have an important effect upon the future growth of Blue Cross plans. Both the American Federation of Labor and the Congress of Industrial Organizations have urged their constituent organizations to secure the establishment of such programs under collective bargaining agreements.

ADVERTISING

The introduction and development of a Blue Cross plan in a community is, in a very real sense, a program of public education. One way of informing or educating the public about a plan is through advertising.

Up until a few years ago the plans did not make use of paid advertising. It was thought that such advertising might be considered inconsistent with their non-profit, civic-service character, and that it might result in the loss of certain free types of publicity which the plans enjoyed.

Since 1942 or 1943 some of the plans have begun to make use of advertising. In the beginning this was mainly for the announcement of new benefits -- it is far cheaper to announce such benefits through advertising than through direct mail. Later some plans began to use advertising in connection with community enrollment campaigns or to announce the acceptance of individual enrollees for a limited period. The experience of these plans with advertising was such as to encourage its further use.

Since 1945 the Massachusetts plan has made extensive and continuous use of advertising. The plan attributes its rapid growth -- except for Rhode Island it leads all other state-wide plans in percent of population enrolled -- to the extensive use of advertising and has been exhorting the other plans to follow its example.

^{5/} *Health Benefit Programs Established Through Collective Bargaining*, by Florence Peterson, Everett Kassalow, and Jean Nelson, *Monthly Labor Review*, August 1945, p. 191. Also *Collective Bargaining Developments in Health and Welfare Plans*, *Monthly Labor Review*, February 1947, p. 191.

ENROLLMENT OF NATIONAL CONCERNS

Special problems arise in the enrollment of employees of national concerns, i. e., concerns having plants or establishments in the areas of two or more plans. The individual plans are often unable to deal with these problems or to spend the time and energy necessary to enroll a concern only a part of whose employees will become members of the local plan. To aid in enrollment of these concerns the plans have established a National Enrollment Office under the Blue Cross Commission.

The diversity of benefits and subscription rates of the plans have been handicapping factors in the enrollment of national concerns. A much more serious problem in the enrollment of national concerns has been the differences in enrollment regulations of the plans. There has been the greatest diversity with respect to such matters as minimum size of groups which would be accepted, minimum percentage of members of the group required, time when new contracts become effective, procedures for group re-openings and enrollment of new employees, etc. (A national concern which wishes to have all of its employees covered and finds that, say, its three branch office employees in a certain city cannot be enrolled because the plan of that area does not accept groups of less than five is naturally dissatisfied.) At the March 1946 conference the plans voted to adopt a set of uniform enrollment regulations and procedures for all national concerns. As of March 1947 the vast majority of the plans had adopted these regulations and procedures.

Another problem in the handling of national accounts arises in the case of those national concerns which pay all employees, wherever they may be located, through the headquarters office and who want a single consolidated billing on behalf of all the plans in which their employees may be enrolled. At the October 1946 conference the plans voted to cooperate in arrangements to provide such concerns with a consolidated billing. It was also voted to establish a consolidated billing office in conjunction with the national enrollment office to handle or expedite such arrangements.

A concrete example may help to make clear what is here involved. An eastern railroad has recently taken Blue Cross protection. This railroad has employees in the areas of more than 20 plans. All of its employees are paid from the headquarters office and it wants a consolidated billing. To develop a consolidated billing on behalf of 20 plans would be too complicated. The arrangement developed is that all of the employees will be enrolled in six principal plans, and these will cooperate in developing a consolidated billing which will be handled by the plan serving the headquarters office of the railroad. The other 14 plans have agreed to provide service benefits under the inter-plan service benefits agreements to the employees hospitalized in their area. In other words, under the arrangement all employees will receive service benefits when hospitalized in the areas of any of the 20 plans.

TRANSFER OF MEMBERS BETWEEN PLANS

Members of a plan, when they move to another area having a plan, usually desire to transfer their membership to this plan in order to have the convenience of payroll deduction and so that, if hospitalized in their new home community, they may receive service benefits. Such persons also desire that the new plan should recognize any period of membership in the old plan in ful-

fillment of waiting periods under the new plan. In order to meet these problems the Commission has stimulated the development among the plans of transfer agreements. At the present time, practically all the plans (there may be two or three exceptions) will unconditionally accept persons transferring from another plan, and will recognize the previous continuous enrollment period in another plan or plans as the basis for meeting their own waiting period requirements.

A NOTE ON THE RELATIONSHIP BETWEEN ENROLLMENT AND INCOME STATUS

The question of what income groups are enrolled by the plans, i. e., to what extent the plans enroll a cross section of the population or whether enrollment is concentrated among the high or middle income groups, is of great importance. Very little definitive data was obtained on this point in the survey. The plans do not have data on the income or occupation of their subscribers.

The Baltimore plan has made an analysis of the areas in which its members reside according to census districts, and has calculated the percentage of the total population of each area which has been enrolled. This information is shown on the accompanying map. By comparison with the map showing the median rent paid in each district, it is apparent that the percentage of enrollment varies with economic status -- as economic status goes up so does the percentage of the population enrolled.

Various surveys or studies indicate, as one would expect, that the plans tend to enroll proportionately more of the better than of the less well off income groups. Thus a survey in Rochester, N. Y. in 1940 showed the following distribution by income of those with and without hospital insurance:^{6/}

INCOME GROUP	ESTIMATED DISTRIBUTION OF ALL FAMILIES AND SINGLE PERSONS	DISTRIBUTION OF THOSE	
		WITH INSURANCE	WITHOUT INSURANCE
OVER \$5,000	7	6	1
\$2,200-4,999	16	11	5
\$1,300-2,199	48	23	25
\$800 TO \$1,299	20	4	16
UNDER \$800	9	0	9
TOTAL	100	44	56

At the time of this survey the Rochester plan had probably enrolled about 40 percent of the population of the city. At the present time the plan has enrolled approximately 75 percent of the population of the city proper. It is evident therefore that in the years since the survey the plan must have extended its enrollment considerably among the lower income groups.

^{6/} Smillie, Wilson, G., M. D., *A Survey of the Facilities for Care of the Sick of Rochester, N. Y.*, Rochester Community Chest, 1941, p. 110.

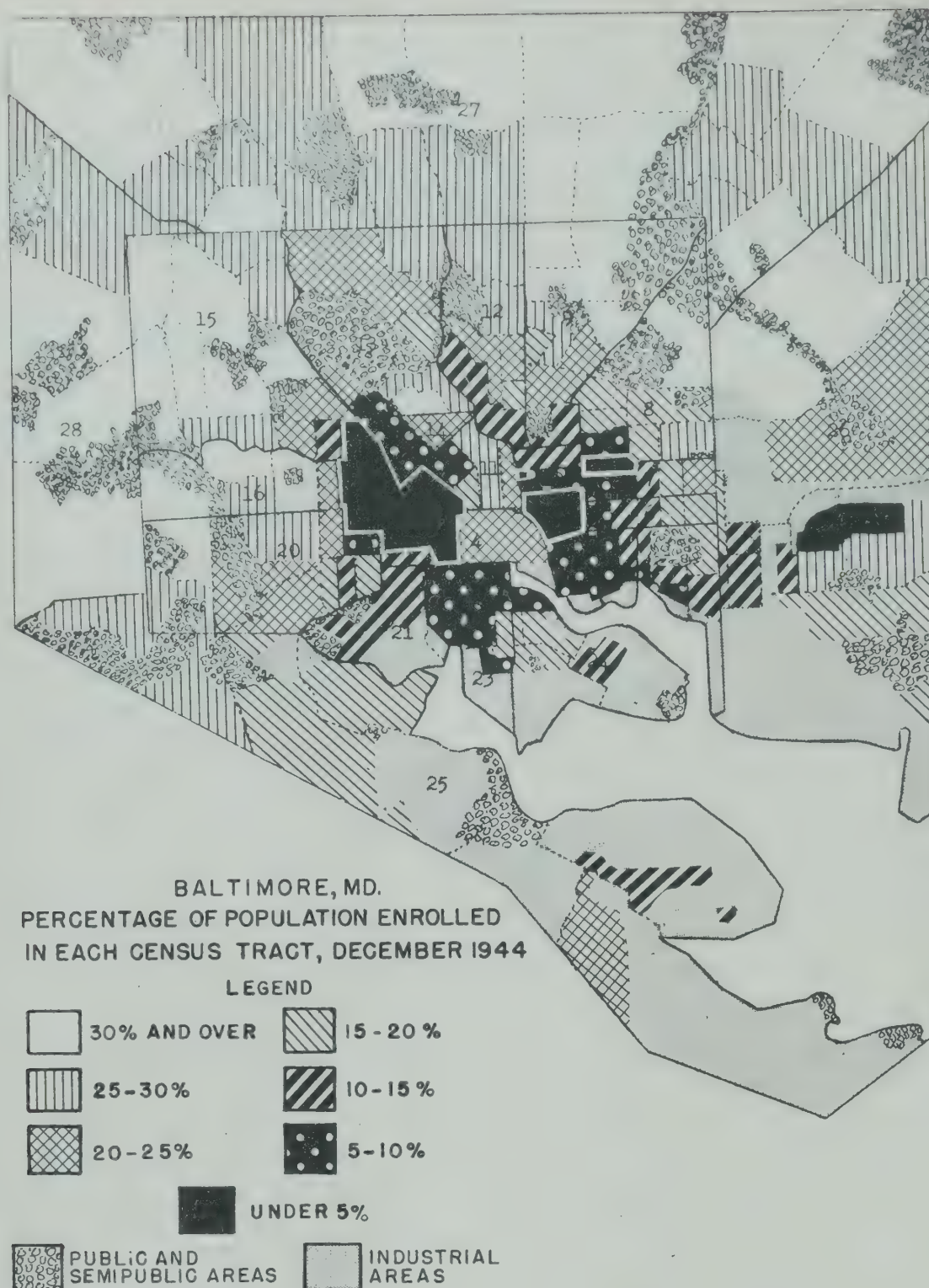


FIGURE 9

A canvass made in Michigan in 1944 found that the proportion among the different occupational groups who belonged to a hospital or medical prepayment plan was as follows:^{7/}

		PERCENT
GROUP A	(EXECUTIVES, PROFESSIONAL MEN, SUCCESSFUL MERCHANTS, ETC.)	49
GROUP B	(WHITE COLLAR AND SKILLED MANUAL WORKERS, ABOVE AVERAGE FARMERS AND SMALL BUSINESS PROPRIETORS, ETC.)	48
GROUP C	(MANUAL LABORERS, STORE CLERKS, SMALL FARMERS, ETC.)	37
GROUP D	(UNSKILLED MANUAL LABORERS, THE SMALLEST FARMERS, CASUAL WORKERS)	28

^{7/} *Public Relations of the Medical Profession, State of Michigan.* Prepared for the Michigan Health Council by the General Research Bureau of Foote, Cone and Belding, Chicago, Ill., 1944.

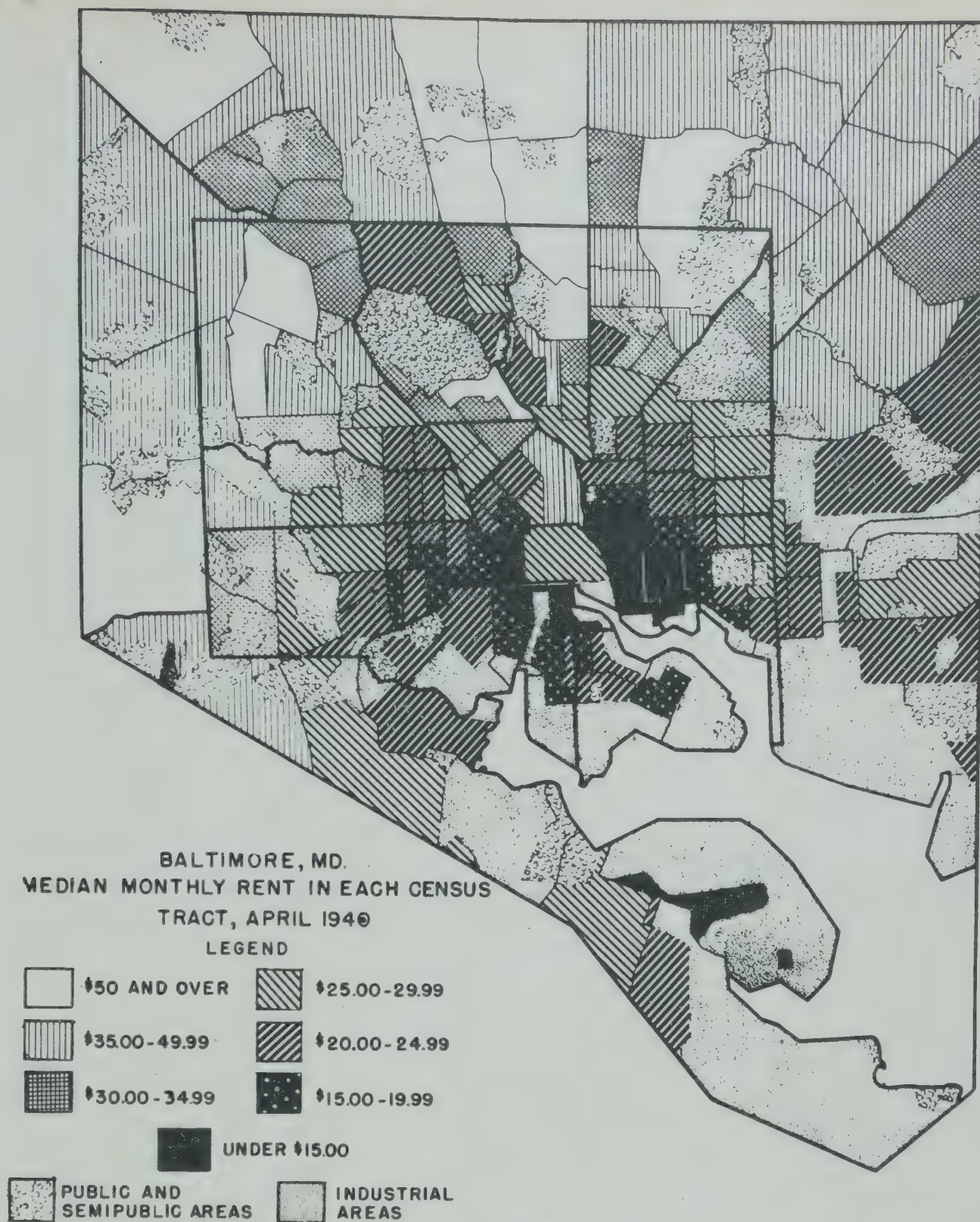


FIGURE 10

Various other surveys also show that the plans have enrolled proportionately more of the upper than of the lower income groups.^{8/} The fact that, as shown in Table 5 (Chapter 3), the plans have enrolled higher percentages of the population in the more prosperous than in the less prosperous States also confirms this general showing.

That the plans have enrolled proportionately more of the upper than of the lower income groups is not equivalent to saying that the plans have their enrollment mainly among the middle or upper income groups. This may well be true in the case of those plans which have enrolled but a small proportion of the population of their area. Where the plans have enrolled appreciable portions of the population, of necessity they must have enrolled large numbers of those in the lower income groups.

^{8/} For example, a survey made by the Commission on Medical Care in New York State. *Medical Care for the People of New York State*, Report of the New York State Legislative Commission on Medical Care, 1946, p. 223.

CHAPTER 7

LEGAL STATUS OF HOSPITAL PLANS* 1/

When Baylor University Hospital in 1929 contracted with school teachers in Dallas to provide hospital care in return for specified payments, the Texas insurance department did not consider the hospital to be engaging in the insurance business. The hospital was simply selling its services on a group or prepaid basis. Later when hospitals in other States established or contemplated the establishment of similar arrangements the attorney generals or departments of insurance in some of these States ruled that the offering of such contracts constituted or would constitute "insurance" and would be subject to the State's insurance code.

Presumably because of such a ruling, the first community-wide hospital service plan, the Sacramento plan, was established as a mutual insurance company. When the next plan, that in St. Paul, Minnesota, was launched early in 1933 its backers assumed that the plan was simply selling the services of its member hospitals and was not engaged in the insurance business. Late in that year the plan was forced by a ruling of the insurance department of the State to re-write its contracts with hospitals in such a way as to make the plan an agent of the member hospitals. Otherwise the plan, in the opinion of the insurance department, would be engaging in insurance.

DEVELOPMENT OF ENABLING LEGISLATION

In 1933 when a group of civic leaders, hospital representatives and physicians desired to start a plan in New York City, the State Superintendent of Insurance ruled that the contemplated activity, although desirable, was one which could only be legally carried on by organizations meeting the requirements for stock or mutual insurance companies. To organize the plan as a stock insurance company would mean that the plan would presumably be for profit and that a large amount of capital would be required. To organize it as a mutual insurance company would mean that the participants would be subject to assessments. The requirements for neither type of organization seemed consistent with what the backers of the contemplated plan had in mind, and accordingly this group sponsored a proposal for special enabling legislation which became law in May 1934.

The same developments occurred elsewhere. From this time on the attorney generals or insurance departments in other States generally held that the offering of hospital service contracts would constitute "insurance", and it became apparent in most States either that plans would have to meet the requirements for stock or mutual insurance companies or that special legisla-

* All data as of May 1, 1946.

1/ In the writing of this chapter, the booklet "State Enabling Legislation for Non-Profit Hospital and Medical Plans, 1944," by Odin W. Anderson, School of Public Health, University of Michigan, has been helpful.

tion would be required. Following New York's lead one State after another has passed laws providing for the establishment and operation of non-profit hospital service plans.

At present (May 1946) 34 States and the District of Columbia have such legislation. The States having such laws and the years in which the initial acts were passed, are as follows: ^{2/}

1934	New York
1935	Alabama, California, Illinois, Maryland
1936	Massachusetts, Mississippi
1937	Georgia, Pennsylvania
1938	Kentucky, New Jersey
1939	Connecticut, District of Columbia, Florida, Iowa, Maine, Michigan, New Hampshire, New Mexico, Ohio, Rhode Island, South Carolina, Texas, Vermont, Wisconsin
1940	Virginia
1941	Kansas, Minnesota, Nebraska, North Carolina
1942	- - - -
1943	North Dakota, West Virginia
1944	- - - -
1945	Arizona, South Dakota, Tennessee

In a number of jurisdictions, plans were started in advance of the passage of enabling legislation. This happened in the District of Columbia, Minnesota, New Jersey, North Carolina, Ohio, Tennessee, Texas, Virginia and West Virginia. In all of these States, except Ohio, the backers of the plan assumed or State officials had originally ruled that the plan did not constitute "insurance". Subsequently the plans came to feel that their legal basis was uncertain or insecure (officials could change their minds or be replaced) and they moved to obtain the passage of legislation which would give them an unequivocal legal status. In Ohio plans were established under a 1903 law which permitted hospital service associations to offer the services of hospitals as the agent of these hospitals. This latter law had certain disadvantages and in 1939 Ohio passed legislation more specifically suited to the needs of the plans.

Blue Cross plans exist in a number of States which have not passed any legislation specifically providing for the establishment of non-profit hospital service plans. In five States -- Colorado, Delaware, Missouri, Montana and Utah -- it has been ruled that the plans do not constitute "insurance" or the plans, despite questioning of their status, have succeeded thus far in maintaining that they are not subject to the insurance code. In two States, Indiana and Oklahoma, the plans are organized as mutual insurance companies. ^{3/}

^{2/} Many of the States have amended their laws two or three times.

^{3/} Repeated efforts in Indiana to obtain enabling legislation failed and the plan was organized as a mutual insurance company because apparently it could be established in no other way. The plan calls itself "Blue Cross Hospital Service". It has been held exempt from Federal income taxes, and is now requesting exemption from a State one percent tax on premiums. The Oklahoma plan was organized as a mutual because the State's Mutual Casualty Act seemed to provide adequate scope for a plan. The plan is called "Group Hospital Service", and pays no taxes except a small licensing fee.

STATES WITH ENABLING ACTS FOR HOSPITAL SERVICE PLANS

(AS OF MAY 1, 1946)

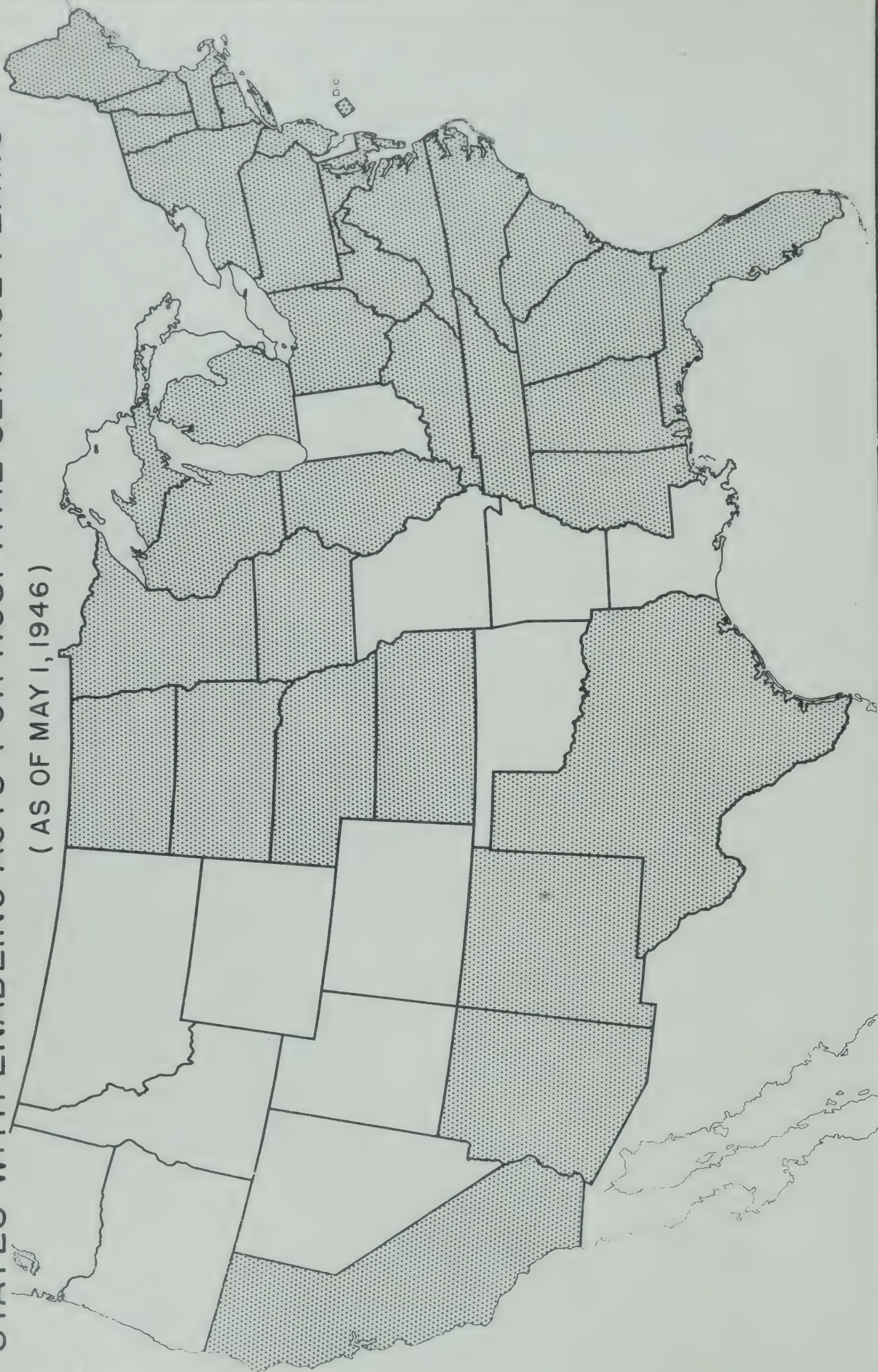


FIGURE 11

The Louisiana plans qualify under a 1938 law providing for service insurance companies. This exempts organizations coming within the definition of service insurance companies from the insurance code and subjects them to licensure, examination and some degree of supervision by the Secretary of State. A 1940 amendment to this act provides that any non-profit mutual association operating a hospital service plan, a majority of the directors of which are administrators, trustees or members of the clinical staffs of member hospitals, shall be exempt from all state and local taxation, except taxes on real estate and office equipment.

The Oregon plan qualifies under a Hospital Association Act passed in 1917 and amended in 1930, which states that organizations contracting to furnish hospital and medical services shall be subject to the provisions of this act, and thus (by implication) exempt from the laws governing insurance. This legislation, which was passed primarily to legalize the operation of commercial hospital associations described in Chapter 1, provides that such organizations shall be licensed by and supervised to some extent by the department of insurance. The plan in Washington functions, from the standpoint of its legal status, as a division of the Oregon plan.^{4/}

The legal status of the plans in the various states may be recapitulated as follows: In 31 States and the District of Columbia the plans function under legislation providing for non-profit hospital service plans.^{5/} In five States, the plans have been organized under the general corporation laws or under laws providing for non-profit organizations and are considered as not engaging in the insurance business. In two States the plans are organized as mutual insurance companies. In three States the plans qualify under legislation designed to authorize and regulate analogous types of organizations. Three States have passed legislation which would permit the operation of hospital service plans but have no plans, although one of these States is partially served by a plan with headquarters in another State. Four States have neither laws nor plans, although one of these is partially served by a plan from another State.

PROVISIONS OF ACTS RELATING TO NON-PROFIT HOSPITAL SERVICE PLANS

All of the 35 acts providing for non-profit hospital service plans have certain common elements.^{6/} All authorize non-profit corporations to contract to furnish hospital service to subscribers, such corporations to be subject to the provisions of the act in question and to be exempt from all provisions of the insurance code, except as otherwise designated.^{7/} All provide that such corporations shall be supervised in certain particulars by the insurance

4/ The hospitals in Washington have been endeavoring to obtain passage of enabling legislation which would permit the establishment of a completely separate plan in that State.

5/ However, the Sacramento plan in California is organized as a mutual insurance company. Also Vermont has enabling legislation but is served by a plan with headquarters in New Hampshire. Both States passed laws which, in effect, permit a plan established in either State to serve the other.

6/ Appendix G gives the text of a "model law" to enable the formation of "Non-Profit Hospital and/or Medical Service Corporations", which has been drawn up by the Blue Cross Commission. Except that this model law provides for plans which can offer both hospital and medical service its provisions are rather typical of those of most of the acts.

7/ Except in Mississippi where a plan could be for profit.

department of the State.^{8/} All provide that such corporations are declared to be charitable and benevolent institutions and exempt from all State and local taxes (except in some cases taxes on real estate).^{9/}

The chief provisions of the acts may be summarized as follows:

BOARD OF DIRECTORS. The composition of the boards of directors of non-profit hospital service plans is mentioned in 24 of the acts. In 10 it is specified that a majority of the directors must be trustees or administrators of hospitals which contract with the plan for provision of service.^{10/} Five acts require that a majority shall be hospital representatives or physicians.^{11/} One act (Alabama) apparently requires all board members to be either hospital representatives or physicians. In four acts it is stipulated that the board must be composed of hospital representatives, of physicians, and of representatives of the public, in equal proportions.^{12/} None of these acts with the exception of that of the District of Columbia states how the public representatives are to be selected. The act of Congress providing for a charter for the plan in the District of Columbia states that the public representatives are to be designated by the Commissioners of the District. A number of acts provide that the board shall include representatives of the hospitals, the medical profession and the public but do not specify the proportions.

HOSPITALS WITH WHICH THE CORPORATION MAY CONTRACT. Almost all of the acts state that the corporation may enter into contracts for the provision of care to subscribers with hospitals maintained by any governmental agency or with hospitals operating under the hospital laws of the State. A few acts have more detailed specifications. The acts of six States stipulate that the plan may only contract with hospitals approved by the State department of welfare.^{13/} In five other States the hospitals must be approved by the insurance departments; ^{14/} in three by the health department; ^{15/} in one (New Jersey) by both the welfare and insurance departments. The Connecticut act specifies that the hospitals must be annually approved by the State Medical Examining and the Homeopathic Medical Examining Boards. A number of the acts specify that the hospitals with which the plan contracts must be approved by certain private organizations. In Alabama the hospitals must be approved by the State hospital and medical associations. In North Carolina the hospitals must be approved by the American Medical Association and/or the State hospital association; in South Carolina by the State hospital association. In three States, the plan may contract only with non-profit hospitals.^{16/} The act of one State (North Carolina) states that "nothing in the act shall be construed to discriminate against hospitals conducted by other schools of medical practice."

Although certain of the acts, as indicated above, make certain stipulations concerning hospitals with which the plan may enter into contracts, only

^{8/} Except in Arizona and Virginia where supervision is exercised by the Corporation Commission.

^{9/} Except in California, Iowa, Mississippi, South Dakota and Tennessee.

^{10/} Florida, Georgia, Illinois, Massachusetts, Minnesota, New Jersey, New Mexico, Ohio, Rhode Island, Texas.

^{11/} California, Iowa, Maine, North Dakota, Wisconsin.

^{12/} District of Columbia, Kansas, Nebraska, Tennessee.

^{13/} Georgia, Illinois, Maine, Massachusetts, New York and Pennsylvania.

^{14/} Florida, Nebraska, New Mexico, South Dakota, Tennessee.

^{15/} California, Kansas, Kentucky.

^{16/} Michigan, New Jersey and Ohio.

one (West Virginia) stipulates that the plan must enter into contract with all hospitals meeting these requirements. ¹⁷/ None of the acts states what recourse a hospital has which is refused a contract by the plan.

HOSPITAL UNDERWRITING. The acts of 14 States stipulate that a plan must be underwritten by its member hospitals. ¹⁸/ This stipulation is usually expressed in terms similar to that in the Michigan act which reads: "All contracts issued by such corporation to the subscribers shall constitute direct obligations of the hospital or hospitals with which such corporation has contracted for hospital service."

SUPERVISION BY THE STATE INSURANCE DEPARTMENT. All of the acts call for some degree of supervision of the plan by a State agency -- with two exceptions the State insurance department. ¹⁹/ All require the submission of financial reports, either annually or at such times as the department may require, these reports to contain such information as the department specifies. Virtually all of the acts, specifically or by implication, gives the insurance department ²⁰/ the additional power of visitation and examination of the organization. ²¹/ A number of the acts require that examinations must be made at least once every three years; most acts do not contain this stipulation.

The great majority of the acts require the corporation, before offering contracts to subscribers, to secure a license or certificate from the insurance department. Such license is given upon submission to and approval by the department of the proposed contracts with subscribers and hospitals, statement of the proposed rates, the articles of incorporation, the names of the directors, etc. Some States require that such a license needs to be obtained only initially; other States require annual licensure.

All except four of the acts require approval by the insurance department of the subscriber contracts and the rates to be charged subscribers. ²²/ Some of the acts provide only for initial approval, i. e., state that any contract to be offered must be approved as to content and rates before it can be offered. Other acts stipulate that the rates charged subscribers shall at all times be subject to the approval of the insurance department.

Few of the acts make any statement as to the basis upon which rates shall be approved or disapproved. The implication in most of the acts is that rates are to be approved from the standpoint of being adequate to provide the stipulated benefits and to preserve the plan in sound financial condition. A few acts recognize that it might be a disservice to the public if rates were higher than necessary so that the plan simply piled up large reserves.

¹⁷/ The law states that "every approved hospital shall be eligible for participation," but does not define an "approved" hospital.

¹⁸/ Arizona, Georgia, Kansas, Maine, Maryland, Michigan, Nebraska, Ohio, South Carolina, Tennessee, Texas, South Dakota, Virginia and West Virginia.

¹⁹/ In Arizona and Virginia this supervision is exercised by the State Corporation Commission.

²⁰/ Or corporation commission. From this point on it will be understood that insurance department refers to corporation commission in the two States where the latter is the supervising agency.

²¹/ The District of Columbia act seems to provide the only exception to this rule.

²²/ Arizona, District of Columbia, Minnesota, and Wisconsin. The Corporation Commission of Arizona must approve the form of the contract but not the rates. The District of Columbia act provides that the plan must annually file with the superintendent of insurance a financial statement. If the superintendent shall have reason to believe that the corporation is not complying with its charter, or is being operated for profit, or fraudulently conducted, he shall cause to be instituted the necessary proceedings to enjoin such improper conduct, or to dissolve the corporation. Beyond this no supervision is exercised.

Thus in New York the superintendent of insurance may refuse approval if he finds that "rates are excessive, inadequate or unfairly discriminatory". The Maine and South Dakota acts require that the rates and benefits shall be "fair and reasonable".

RATES OF PAYMENT TO HOSPITALS. The acts of 19 States specify that the plan's rates of payment to hospitals shall be subject to the approval of a State agency. In 15 of these States rates of payment are to be approved by the insurance department;^{23/} in three States by the welfare department.^{24/} An additional State (New York) requires that rates of payment to hospitals shall be approved "as to adequacy" by the welfare department and "as to reasonableness" by the insurance department.

RESERVES. It would seem that in almost all States the insurance department has some power to influence the amount of reserves maintained by a plan owing to its supervision of the rates to be charged subscribers. The acts of 13 States make specific mention of reserves. In four States, the acts simply specify that adequate reserves shall be maintained.^{25/} In the other nine States the law names specific amounts of reserves which the plans must maintain as a minimum.^{26/} The New York law requires that plans shall each year set aside in a contingent surplus fund not less than four percent of net premium income until this fund amounts to 25 percent of the year's net premium income. This fund may not be reduced below this limit except with the approval of the superintendent of insurance. In most acts specifying a minimum amount of reserves, the minimum so specified is so low as to be totally inadequate for a large plan.^{27/} For example, the California act stipulates that a plan with over 5,500 subscribers must maintain a reserve of at least \$20,000. The New Jersey act requires that a plan should add to its special contingent surplus at the rate of two percent of its net premium income, until such surplus shall be not less than \$100,000.

The North Carolina act is the only one which sets maximum as well as minimum limits to reserves. This act requires plans to set aside certain percentages of gross premiums until contingent reserves are not less than three times nor more than six times monthly expenditures for hospital claims and administration.

ADMINISTRATION AND ACQUISITION COSTS. Provisions relative to these costs are contained in 24 acts. In eleven of these it is stated that administration and acquisition costs are at all times subject to the approval of the insurance

23/ California, Florida, Georgia, Iowa, Maryland, Michigan, Nebraska, New Mexico, North Dakota, South Carolina, Pennsylvania, South Dakota, Tennessee, Texas, West Virginia.

24/ Illinois, Massachusetts, New Jersey.

25/ Maine, Michigan, Pennsylvania, Virginia. The Virginia act which is not clear in many respects states: "It shall not be necessary except as may be required by the State Corporation Commission in the exercise of its discretion and with a view to the ultimate success and continuance of any plan... that there be any particular reserve, or that rates for the services be necessarily sound and proper from the actuarial standpoint, but the Commission... shall take into purview the financial and moral responsibility, and the ability and capacity to render the services contracted for..."

26/ Alabama, Arizona, California, Kentucky, New Jersey, New York, North Carolina, South Carolina, Tennessee.

27/ The Blue Cross Commission has recommended that plans maintain a reserve of about five times monthly income or seven times monthly hospital expense. (The 1946 revision of the standards of approval for Blue Cross plans of the American Hospital Association requires an approved plan, in the absence of hospital-responsibility for contract-benefits, to establish a reserve equal to 25 percent of current annual income.)

department.²⁸/ In six acts, acquisition costs alone are subject to this approval.²⁹/ In the other seven it is stipulated that acquisition or administration cost, either separately or combined, shall not exceed a certain percentage of income.³⁰/ The New York law, for example, specifies that (after the first two years) no plan may spend more than 10 percent of income for acquisition nor more than 20 percent for administration. The Kansas law imposes limits of 10 and 15 percent respectively for these purposes. In virtually all cases the percentage of income so specified are far above those which the plans in these States are actually spending for these purposes. The acts of a considerable number of States forbid the employment of salesmen or agents on other than a salaried basis.

DEFINITION OF HOSPITAL CARE OR HOSPITAL SERVICE. The vast majority of the acts do not define hospital care or hospital service. Whatever services are customarily furnished by hospitals can be included under the plan. A few states (Iowa and North Dakota, and possibly others) define hospital service in such a way as to exclude x-ray, pathology and anesthesia services, thereby reflecting the desire of the medical profession in some places that these services should not be included under a hospital service plan. The California law defines hospital services as including "indemnification of the beneficiary or subscriber for the costs and expense of professional medical service rendered during hospitalization."

MEDICAL SERVICES. In the last three years a number of States have passed legislation providing for the formation of joint hospital and medical service plans or amending their existing hospital service plan act so as to permit the hospital service plan to provide medical services as well as hospitalization. In most cases so far the wording of the legislation does not take full cognizance of the implications of the step taken, i. e., the law still speaks of the plan as a "hospital service plan" even though it can offer medical as well as hospital services. In one instance, Maryland, the full implications of the step have been recognized. Here the amended law omits all reference to a hospital service plan and speaks simply of "health service plans" which may offer hospital, medical, dental and other health services.

At present, (May 1946) in nine States (Alabama, Arizona, Florida, Maine, Maryland, North Carolina, Rhode Island, Virginia and West Virginia) one plan (whether described in the law as a hospital service plan, a medical and hospital service plan or a health service plan) may offer both hospital and medical services to subscribers. Maine and North Carolina amended their acts in 1943 so as to permit the hospital service plan to cover medical services as well. Alabama did the same in 1945 and provided for medical representation on the Board of the plan which previously could be composed of hospital representatives only. Maryland transformed its hospital service plans act into a health service plans act in 1945. In the same year Florida passed an entirely new act providing for "non-profit medical and/or surgical and/or hospital service plan or plans". The Arizona act also passed in 1945 likewise provides for hospital

28/ Connecticut, Georgia, Iowa, Kentucky, Michigan, Nebraska, New Hampshire, North Carolina, North Dakota, South Carolina, South Dakota.

29/ Alabama, Florida, Massachusetts, New Mexico, Pennsylvania, Virginia.

30/ Arizona, California, Kansas, New Jersey, New York, Tennessee, Texas.

or medical service plans or combinations thereof. In the same year Rhode Island passed an act providing for non-profit medical service corporations, one paragraph of which specifies that a corporation organized under the hospital service plan act may, with the consent of the Rhode Island Medical Society, amend its articles of association and exercise the powers of a non-profit medical service corporation. The 1940 Virginia Act apparently permits one corporation to offer both hospital and medical service. The West Virginia amended act passed in 1946 provides for hospital service corporations and medical service corporations. Apparently one organization could offer both hospital and medical services.

If the passage of the above legislation constitutes a trend it is one which presages a thorough transformation of the existing legislation relating to hospital service plans. The provisions relative to medical services of the laws in the above-mentioned States will be described in the chapter relating to the legal status of medical service plans.

ADMINISTRATION OF LAWS RELATING TO HOSPITAL SERVICE PLANS

Laws which are on the statute books may or may not be effectively carried out. To what degree, in practice, are hospital service plans supervised by insurance departments in accordance with the respective laws? Upon this point we are only able to offer impressions founded in most cases upon statements by the plan directors. The impression was received that, by and large, the character and degree of supervision varied with the strength of the insurance department of the State. In States, such as New York and Massachusetts, with strong, well-financed departments the laws relating to the plans are ably administered, and the plans are subjected to a close, understanding, and helpful supervision. In States, where the insurance departments are weak -- where they are meagerly financed or poorly staffed -- then the supervision exercised is often not at all close. The situation in the various states ranges between these poles. In at least two States with plans but no legislation, the plans are opposed to the passage of legislation because they believe that supervision by the state insurance department would be detrimental rather than helpful.

In most States the supervision has been directed solely towards seeing that the plans are in a sound financial condition and able to meet their obligations to subscribers. Only in a few instances has the supervision aimed to assure that the plans provide maximum service to the subscribing public and the community at large.

STATUS OF PLANS UNDER FEDERAL TAX LEGISLATION

The plans are affected by Federal tax legislation. The plans have been ruled exempt from Federal income taxes as meeting the requirements of an "organization for social welfare". The plans have been ruled not exempt from social security taxes, not being regarded as charitable organizations under Chapter 9 of the Internal Revenue Code.

CHAPTER 8

THE CONTROL OF HOSPITAL PLANS

Hospital service plans are controlled by their boards of directors. These boards appoint the executive director of the plan and decide all larger matters of policy. Most commonly the boards consist of from 10 to 20 persons. Usually they are composed of persons designated to represent the hospitals, the medical profession and the public.

SELECTION OF BOARDS OF DIRECTORS

The boards are appointed or elected in a great variety of ways. Some typical arrangements may be cited by way of illustration.

The Maryland plan has a board of 14 directors, who are elected by the members of the corporation. Each member hospital designates one member of the corporation. The Baltimore medical society designates an equal total number of members. The hospital members of the corporation elect four hospital and three public representatives and the medical members elect four medical and three public representatives.

The Chapel Hill (N.C.) plan has a board of 12 members. Four are selected by the State hospital association and four by the State medical association. These directors elect four other directors to represent the public.

The New York City plan has a board of 25. Directors are selected by the voting members of the corporation who consist of the directors of the United Hospital Fund (prominent civic leaders), the presidents of the Greater New York Hospital Association, the Brooklyn Hospital Council, the New York Academy of Medicine, the State Medical Society, and the medical societies of each of the five boroughs of New York City. The directors are chosen from four categories, six from the hospitals of whom three must be administrators and three trustees, six from the medical profession, six from subscribers, and seven "at large" chosen from among persons who would be eligible for election in any other category. Directors of the first three categories serve for three years each and those from the fourth category for one year. The six medical members are nominated from names sent in by the medical societies. The three hospital administrators are nominated from names sent in by the hospital associations. The three hospital trustees are nominated from names submitted by the nominating committee of the board. The seven "at large" directors are chosen so as to have three represent large subscriber groups, two to represent the point of view of labor, one to represent the point of view of proprietary hospitals, and one is the president (executive director) of the corporation.

The Rochester plan has a board of 34. The board is self-perpetuating, i.e., new directors are elected by the existing directors. The by-laws specify that a majority of the executive committee of nine which largely manages the plan shall be hospital trustees.

The board of the Kansas plan, in accordance with State law, is composed of an equal number of representatives of the hospitals, the medical profession and the general public. The directors are elected by the members of the corporation, con-

sisting of the original incorporators and such other persons as are elected by the directors.

The Los Angeles plan has a board of 18. Each member hospital is a member of the corporation. The members of the corporation at an annual meeting elect the board. The by-laws stipulate that six of the directors shall be hospital representatives and six shall be physicians.

The Michigan plan has a board of 28. The by-laws specify that 13 of the board members shall represent the hospitals, of whom seven shall be trustees and six administrators (or vice versa), six members shall represent the medical profession and nine shall represent the public. The hospital representatives are nominated by the hospitals in each of the nine districts, at least two persons being nominated for each representative to be elected. The board of trustees elects the representatives of the hospitals from the persons so nominated, the medical representatives from persons designated by the State medical society, and the public representatives.

The methods by which the boards of directors are selected appear to fall into five main categories. Three of these are of relatively equal frequency; the other two are far less common.

In 11 of the 38 plans^{1/} surveyed, the hospital representatives on the board are elected or designated by the member hospitals, the medical representatives are elected or designated by the local or state medical society, and the board members thus elected, in effect, elect a number of other board members to represent the public.

In 10 of the 38 plans, the board is self-perpetuating, i.e., new members of the board are elected by the board itself. These plans may or may not have by-laws specifying a certain composition of the board, for example, that a majority must at all times be trustees or administrators of hospitals. In some of the plans with this type of arrangement, the self-perpetuation of the board is indirect, i.e., the board is elected by the members of the corporation who in turn are elected by the directors. Sometimes board members and members of the corporation are one and the same persons.

In nine of the 38 plans surveyed, the member hospitals elect or designate some members of the board. The board, as a whole, elects the other board members. In other words the board is partly self-perpetuating, partly selected by the member hospitals.

A less common arrangement, which obtained in five of the plans visited, is one where all the members of the board are elected or appointed by the member hospitals. Usually these boards have one or more physicians on them, but the by-laws do not specify that any physicians appointed shall be named or designated by the medical society.

The least common arrangement, which occurred in only three of the plans surveyed, is where the members of the board are elected by vote of the subscribers, each subscriber being entitled to one vote. In practice, such boards are self-perpetuating.

In the great majority of the plans, the directors who represent the hospitals or the medical profession are, in fact, elected or appointed by those whom they are to represent. Thus the board members representing the hospitals may be appointed or designated by the member hospitals, if these are not too numerous, or elected by the State or local hospital association, or appointed

^{1/} At the time of the survey the Washington and Oregon plans, though they functioned largely as separate plans, were from a legal standpoint one plan.

by the duly constituted officials of such association. Similarly the board members representing the medical profession are elected by the local or State medical association or appointed by the duly constituted officials of this association.

Such is not the case with the so-called public representatives. With some few exceptions which will be described later, persons designated to represent the public are (a) elected either by the representatives of the hospitals and the medical profession, or by persons who in the first instance were appointed or elected by such representatives, or (b) they are elected by the existing board members. Though the public representatives may have the public's benefit, as they see it, solely in mind, nevertheless they are not elected by the subscribing public or their duly constituted representatives.

COMPOSITION OF BOARDS

The by-laws of most plans specify that the Board shall be composed of persons designated to represent, or selected by, the hospitals, the medical profession and the public in certain numbers or proportions. As indicated in the last chapter, in a number of States the enabling act specifies to a certain degree the composition of the board. In 10 States a majority of the board must be hospital administrators or trustees; in six States a majority must be composed of hospital administrators, trustees, or physicians; in four the board must be composed one-third of hospital representatives, one-third of physicians and one-third of representatives of the public.

Table 8 shows the composition of the Boards of the surveyed plans at the time of visit. Where the by-laws of the plan did not provide for the designation of directors as representatives of one or the other of the three groups, board members who were hospital trustees or administrators were classified as hospital representatives, physicians were classified as representatives of the medical profession, and lay persons who were neither hospital trustees nor administrators were classified as representatives of the public.

It will be apparent that in most cases there is representation, formal or informal, of all three groups. In general there is more representation of the hospitals than of either of the other two interests. In a little over half of the plans (21 out of 39) the persons selected by the hospitals to represent them or who, being either hospital administrators or trustees, could be classified as hospital representatives, constitute a clear majority of the board. In a few plans (6) there is equal representation of the three groups or interests. If one takes all the plans together, giving equal weight to each, 55 percent of the directors are representatives of hospitals, 17 percent are representatives of the medical profession and 28 percent are representatives of the public.^{2/}

These figures as indicative of the proportional representation of the different groups or interests do not take account of two fundamental factors. The first is that frequently the public representatives are elected by the hospitals and the medical profession or by the representatives of these groups. The second factor is that generally, as Table 8 shows, the representatives of hospitals consist of two sorts of persons: hospital trustees and hospital

^{2/} To obtain these figures, the number of directors in each plan was taken as 100 percent and the percent of the representatives of each group to the total was calculated. The figures for all plans for which complete data were available were then added together.

TABLE 8

Composition of Boards of Directors of Surveyed Plans

Data as of time of survey (Mar. 1944 - Feb. 1945)

REPRESENTATIVES OF					CHARACTER OF HOSPITAL REPRESENTATIVES		
PLAN	TOTAL NO. OF DIRECTORS	HOSPITALS	MEDICAL PROFESSION	THE PUBLIC	LAY TRUSTEES	ADMINIS- TRATORS OR OWNERS	PHYSICIANS OTHER THAN ADM. OR OWNERS
ALABAMA †	61	61	0	0	a/	b/	a/ b/
LOS ANGELES, CAL. †	18	6	6	6	a/	a/	a/
OAKLAND, CAL. †	9	3	3	3	0	3	0
SACRAMENTO, CAL. †	7	3	2	2	0	3	0
COLORADO	15	8	2	5	3	3	2
DELAWARE	16	8	4	4	8	0	0
ATLANTA, GA. *	11	8	3	0	4	4	0
SAVANNAH, GA. *	23	12	0	11	3	5	4
ROCKFORD, ILL. *	7	4	1	2	3	1	0
DES MOINES, IOWA †	16	9	2	5	7	2	0
TOPEKA, KANSAS *	24	8	8	8	6	2	0
NEW ORLEANS, LA.	22	16	1	5	11	4	1
MAINE †	14	7	3	4	7	0	0
MARYLAND	14	4	4	6	1	3	0
MASSACHUSETTS *	18	10	5	3	5	4	1
MICHIGAN	28	13	6	9	7	6	0
MINNESOTA *	17	14	2	1	5	9	0
ST. LOUIS, MO	15	c/	c/	c/	c/	c/	c/
KANSAS CITY, MO.	12	4	4	4	a/	a/	0
NEBRASKA *	60	20	20	20	6	14	0
NEW HAMPSHIRE	17	a/ d/	a/	a/	a/	a/	a/
NEW JERSEY *	30	16	7	7	13	3	0
NEW YORK CITY, N.Y.	25	6 e/	8 e/	11 e/	3	3	0
ROCHESTER, N.Y.	36	20 f/	5 f/	11	15 f/	0	5 f/
UTICA, N.Y.	39	g/	g/	g/	g/	g/	g/
CHAPEL HILL, N.C.	12	4	4	4	0	4	0
DURHAM, N.C.	5	5 h/	0	0	4 h/	1	0
CINCINNATI, OHIO *	27	15	2	10	14	1	0
OREGON †	7	4	1	2	0	4	0
PHILADELPHIA, PA.	27	12	6	9	9	3	0
WILKES-BARRE, PA.	12	12 j/	0	0	11	0	1
RHODE ISLAND *	20	11	1	8 k/	10	0	1
TEXAS *	21	12	3 l/	6	2	10	0
LYNCHBURG, VA.	15	9	2	4	6	3	0
NORFOLK, VA.	10	10	0	0	7	0	3
RICHMOND, VA.	15	7 m/	1	7	1	6	0
ROANOKE, VA.	19	10	2	7 n/	1	7	2
HUNTINGTON, W. VA.	13	6	2	5 n/	1	5	0
WASHINGTON o/	7	4	2	1	0	4	0

NOTE: In those cases where the by-laws of the plan did not specify that directors shall be chosen by the various parties or designated to represent them, directors were classified on the basis of their affiliation, i. e., persons who were hospital administrators or trustees were classified as hospital representatives, physicians were classified as representatives of the medical profession and lay persons not affiliated with hospitals were classified as representatives of the public.

FOOTNOTES: * State law specifies majority must be hospital trustees or administrators.
 † State law specifies majority must be trustees, administrators or physicians.
 # State law specifies one-third must be hospital trustees or administrators, one-third physicians, and one-third public representatives

- a/ Information not obtained.
- b/ There are 38 M.D.'s on the Board, most of whom are probably administrators or owners of hospitals.
- c/ Plan does not designate board members as representatives of the various groups except to stipulate that three members of the Board shall be representatives of the medical profession and three shall be hospital administrators.
- d/ Majority of board must be administrators or trustees.
- e/ Differs from the provisions of by-laws which are as of a later date. The given number of public representatives includes the plan's director. The given number of representatives of the medical profession includes two physicians selected as directors "at large".
- f/ The board is self-perpetuating and board members are not designated as representatives of the various groups. There are 20 hospital trustees of whom five are physicians. There are five other physicians.
- g/ The board is self-perpetuating and board members are not designated as representatives of the various groups. There are 24 hospital trustees, one of whom is a physician. There are seven other physicians.
- h/ None of these are hospital trustees though they are appointed by hospitals.
- i/ Executive Committee for Oregon.
- j/ Board members are not designated as representatives of the various groups. All board members happen to be hospital trustees but this is not obligatory. Many were picked not because they were hospital trustees but because they were civic leaders.
- k/ Three of these are physicians.
- l/ One of these owns a hospital.
- m/ Includes six physicians.
- n/ Includes the executive director.
- o/ Executive Committee for Washington.

administrators, the former being the more numerous (a total of 173 as against 117). In terms of their attitude towards the plan and the interests which they represent in reality, trustees and administrators tend to be quite different.

A hospital administrator is interested primarily in his own hospital. He will tend to consider questions of plan policy -- at least where plan policy affects the hospitals -- largely in terms of the effect of this policy upon hospitals in general and his own hospital in particular. The hospital trustee, on the other hand, is generally a civic leader. He will probably be a successful man of affairs -- the head of a large concern, a banker, a leading lawyer, etc. He has been asked to become a hospital trustee because of the confidence which people of the community repose in him and because of his interest in the hospital as a means of serving the public. On a plan board, this individual has an allegiance, so to speak, both to his hospital and to the plan and in any conflict of interest between the two, such as might arise over remuneration, he will tend to weigh the interests and needs of both and try to arrive at a fair decision. Generally he tends to view the plan as an agency designed to serve the public or both the public and the hospitals, rather than one designed to serve primarily the hospitals. In practice, therefore, the hospital trustee on a plan board frequently has about the same attitude toward the plan and is as much a representative of the public as those designated specifically as public representatives.^{3/}

If one takes this latter circumstance into consideration, then one reaches quite different conclusions as to the proportionate representation of various interests on plan boards. For example, the Delaware plan has eight so-called hospital representatives on its board of 16. But all of these hospital representatives are hospital trustees, not one is an administrator. In effect the plan board is made up of 12 lay civic leaders and 4 physicians.

^{3/} Hospital administrators have a common saying to the effect that when a hospital trustee gets on a plan board he is lost as a hospital trustee. By this they mean that his interest in the hospital becomes subordinate to his interest in the plan

For all of the surveyed plans together, if one classifies hospital trustees as representatives of the public rather than as representatives of hospitals, then it appears that of all board members, giving each plan equal weight, 57 percent are representatives of the public, 21 percent representatives of the medical profession and 22 percent representatives of the hospitals. This summation is quite different from that previously given. The truth probably lies somewhere in between.

THE REPRESENTATION OF THE PUBLIC

It has previously been pointed out that while in most cases the representatives of the hospitals and the medical profession are democratically selected, in that they are elected or selected by those whom they represent, this is not the case with representatives of the subscribing public. Some of the plans have been conscious of this problem and have endeavored to meet it in one way or another. The matter obviously presents difficulties. With several hundred or several thousand subscriber groups, ranging in size from, say, 5 up to 10,000 persons it is difficult for a plan to arrange for selection of five or ten persons who may be said to represent the subscribers.

The device of giving each subscriber a vote and having them elect some or all of the directors obviously does not work well. Under such a situation subscribers have no means of voting intelligently, the attendance at the annual meeting is negligible, virtually all votes are cast by proxy, and the slate nominated by the existing directors is elected. Such a process also runs the risk that a small group of subscribers with some special interest might be rounded up to vote for an alternative group of directors, who really might be far less representative of the whole body of subscribers than those picked by the existing board.

A few plans endeavor to obtain direct representation of the subscribers in one way or another. The Massachusetts plan provides that its board of directors shall be elected by the voting members of the corporation. The State hospital association and the State medical society are each members and are allotted 25 votes each; two votes each are allotted to the Boston Council of Social Agencies and the Associated Industries of Massachusetts, and 46 votes are allotted to large subscriber groups, selected by turns, each of which has one vote. This arrangement looks well on paper. However, since the representatives of the subscriber groups are brought together only once -- to vote for a previously nominated slate of directors -- one can doubt whether it results in effective representation of the subscribers. However, if an important issue involving control of the plan were to arise, if subscribers felt that their interests were being slighted, it is possible that the arrangement would provide a means whereby subscribers could influence control of the plan.

The arrangement of the New York City plan, that in which places on the plan's board are given in turn to representatives of large subscribers groups, has already been described.

The Philadelphia plan provides that a certain number of its "public representatives" shall be nominated by the board of directors but elected at an annual meeting of the subscribers. Subscribers who have been members for three years or more are eligible to vote. Nomination may be made from the floor. In a recent year the plan spent several thousands of dollars to advertise the annual meeting, but only 10 or 20 subscribers appeared. The arrangement is democratic in theory but obviously doesn't work in practice.

The District of Columbia plan has a distinctive method of selection of its public representatives. The Act of Congress providing for the incorporation of the plan specifies that the Board of directors shall be appointed one-third by the hospitals of the city, one-third by the medical society and one-third by the commissioners of the District of Columbia. This appears to be a good device for obtaining effective representation of the public. (However, in this particular instance it does not seem to have resulted in making the plan especially responsive to its subscribers.)

The Cincinnati plan has developed a unique arrangement for giving the subscriber a voice in the plan -- the Subscribers' Councils. In each major area of the plan each enrolled group is asked to send a representative -- this can be either a member of the firm, the personnel director, a union representative, or whomever the employer or the group selects -- to a Council. This meets once a year, hears officers of the plan report, discusses affairs of the plan, and elects a so-called regional Subscribers' Committee. These committees meet on call and combine to form a Subscribers' Committee for the plan as a whole, composed of some 80 members. The Chairman -- changed every year -- of this Committee is automatically a member of the Board of Trustees.

The Subscribers' Committees are not self-actuating. A member of the staff of the plan acts as secretary and makes the arrangements for meetings, etc. The Committees do not meet at regular intervals, only when there is something to discuss.

These subscribers' councils and committees have been useful, probably more so in the smaller than in the larger places. They have aided in making the members feel that the plan is their own, have provided an effective sounding board for the membership, and have provided a means whereby the plan can ascertain the desires of its members and explain the need for changes. The organizations have been especially useful on occasions when the plan was considering changing its contract, providing more inclusive services, increasing rates, etc.

The Kansas plan has developed members' councils along similar lines.^{4/} The County Health Improvement Associations organized by the Des Moines, Iowa

4/ The organization of these councils and the spirit in which they are being developed is indicated in the following letter from the plan's director of public relations:

"Our Directors felt that as we build a Blue Cross Movement here in Kansas we should provide channels through which the Members could express their desires as to the kind, quality and extent of hospital care which they would like to provide for themselves on a prepaid basis.

"Accordingly we sent out regular announcements to all groups as they were formed to the effect they could appoint a Member to a local Subscribers' Council. We then formed these Councils in strategic communities with the four fold purpose of:

1. An up-to-date, comprehensive report by the Blue Cross representative.
2. Consideration by the Council of any criticism, whatever its nature.
3. Discussion of ideas for the further development of service to be rendered through the Blue Cross.
4. Discussion of plans for additional members. At the discretion of the Council, subsequent enrollment campaigns will be held under its auspices.

"The results of the discussions in local Councils were to be brought, through a representative, to a State Subscribers' Council at Topeka, meeting annually. The recommendations of this body have been brought to the Board of Directors' Annual Meeting through the Chairman of the Council who was automatically a member of the Board.

"Meanwhile, however, we have been rapidly developing a method of county-wide enrollment with an emphasis on the word membership as against subscriber and are developing County-wide Members' Councils who are to appoint committees who will act as local Blue Cross headquarters for matters of information, enrollment, plans for future growth and development and references in case of local difficulty in the operation of the plan.

"It is the belief of the Directors and of the People here in Kansas that a consciousness of membership will make Blue Cross essentially a Peoples Movement. Through such a Movement they will provide in good times and bad for the continuity and extension of health services which they want and for which they are willing and able to pay."

plan, and described in a preceding chapter, tend to fulfill the same purpose, i.e., of developing two-way communication with the members and of making the plan responsible to the membership.

All of the above constitute special devices of one sort or another for securing democratic representation of the subscribing public. The main method used by the plans is that of electing to their boards as public representatives individuals who, it is thought, will in spirit be representative of the general public, and who will bring to the plan judgment, acumen, experience of affairs and a willingness to devote much time and thought to the problems of the plan.

Most of the public representatives on plan boards are business or professional men -- heads of large concerns, lawyers, bankers.^{5/} One finds an occasional plan with a representative of a church group. Frequently the boards will contain one or more persons active in a women's organization, a community agency, etc. There are approximately 15 plans which have officials of labor unions on their boards.^{6/} A few have representatives of farm organizations. In general there is far more representation of business or employers than of labor or farm groups and in some plans one gets the impression that the so-called public representatives, although they have the public interest as they see it in mind, are quite far away from or out of touch with those whom they are supposed to represent.

These hospital plans are large organizations, some of them with an income of millions of dollars a year. They need competent management. How to secure this while at the same time assuring that the organization will be responsive to the subscribing public is a problem which is not easy to solve.

WHO CONTROL THE PLANS?

In practice, the numerical representation of one group or another on the plan board may indicate little as to the real control of the plan. The real control of a plan seems to depend largely upon the play of personalities. It depends first upon the relationship of the plan's director and his board, to what extent the director dominates the board or the board dominates the director. Then it depends upon the personalities on the board. Individuals who are keenly interested in the plan, who devote much thought to it, who always attend meetings, and whose judgment is sound, so that time and time again they make the right decisions -- such individuals exercise an influence beyond all proportion to their number. Two or three such key individuals often come to exercise such real leadership that they, together with the plan director, really control the plan.

The question, "Who controls?" is inevitably bound up with the question "Controls for what?" This necessitates a discussion of the interests of the various participants.

5/ The character of the public representatives of the Philadelphia plan is probably typical. This plan has six public representatives, and three directors are selected by the Bishop of the Catholic Archdiocese of Philadelphia (this last is not typical). At the time of the visit to the plan these nine directors were: a lawyer, a judge, the head of a leather company, a partner in an investment banking concern, the head of an educational institution, a Federal government official, the President of the League of Women Voters, the president of a telephone company, a physician (the last, an appointee of the Bishop).

6/ Statement of C. Rufus Rorem, Director of the Blue Cross Commission, in the Hearings before the Senate Committee on Education and Labor, 79th Congress, Second Session, on S. 1606, Part 2., p. 947, April, 1946.

In theory the executive director of a plan and his staff are the servants of the plan board; their function is to carry out the policies decided by the board. In actuality the plan director (and in a large plan his key staff) play important roles in the formulation of policy. The plan director works at the plan's affairs eight hours a day; he lives with the plan problems constantly; he has a technical competence or familiarity with the affairs of the plan which exceeds that of the board members; he has at his finger tips the information required for determination of policy. Hence it comes about that a strong executive director will be a leader in the development of plan policy, and that he will be constantly educating his board as to necessary courses of action.^{7/} (However it is also true that a plan director who gets out of touch with his board, who does not faithfully carry out policies decided by the board or endeavors to lead them in directions that they do not wish to go is apt sooner or later to be out of a job.)

The primary interest of the plan director is to make the plan a success. Success is very largely measured by the number of subscribers and maximum growth is fostered by offering the most attractive possible proposition to the public, i.e., by giving as much as possible in benefits for as little as possible. The plan director is, of course, interested in salary and the security of his job, but favorable prospects here go along with the success of his plan. The plan director will know that if the plan is to succeed it must have the enthusiastic support of its hospitals. Such support will not be forthcoming unless the hospitals are fairly remunerated for their services. But this is regarded as a means and not an end. Practically without exception, the directors of all the plans surveyed felt that the primary purpose of their plan was to serve the public. With few exceptions, they regarded the plan not as an agency of the hospitals, but as a civic enterprise.

Hospitals wish the plans to succeed because of the benefits to the public and themselves. At the same time hospitals want to be fairly paid for their services and there may be differences of opinion as to what constitutes fair remuneration. Sometimes what the hospitals think is fair remuneration is more than other interests on the plan board think they (the hospitals) should have.

It is true that virtually all hospitals, at least in point of bed capacity, are not for profit and have no other aim than to serve the public, i.e., to provide the best service at the lowest cost. Nevertheless it is possible for hospitals to benefit themselves at the expense of the plan (and vice versa). Again under a situation in which a large proportion of the population was enrolled and hospitals were paid on a cost basis, hospital administrators would wish in general to provide a more and more perfect or elaborate service, and to make this possible would ask for higher and higher rates of payment. At some point the public would desire to call a halt, preferring to spend its money for other purposes. In the long run the public should and will desire to say how much it should spend for hospital care, and will not be content to leave this decision to the hospitals.

7/ It may be pointed out that nationally the Blue Cross movement really consists of the plan directors. The semi-annual conferences of the plans at which important decisions affecting all the plans are made are attended mainly by the plan directors and key staff members; few board members attend. (At the April 1947 conference there were perhaps 10 trustees present.) The Blue Cross Commission under the new reorganization will be composed of 12 plan directors and 3 representatives of the American Hospital Association.

As indicated previously hospital administrators faced with the day to day problem of balancing their hospitals' budgets frequently look at the problem of remuneration through the glasses of their own needs. Trustees tend to look at the situation broadly and to weigh both the needs of hospitals and the needs of the plan.

The medical profession's main interest in hospital service plans is that they facilitate the provision of care to patients. The profession's interests on this side are largely the same as those of the general public, it wishes to see rates as low as possible and benefits as broad as possible in order that the plan may have a maximum growth. The profession also wishes to see the plans remunerate hospitals fairly and adequately, because otherwise standards of hospital care would be lowered. Various groups of physicians, the roentgenologists, pathologists, anesthetists, have had special interests relative to the plans. They have been concerned, at times, to have their services excluded from hospital plans on the ground that they were medical services and should not be offered under a hospital plan. Where their services have been offered they have naturally wanted the remuneration paid for these services to be adequate, and there may be difference of opinion between these specialists on the one hand and the hospitals or the plans on the other hand, as to what constitutes adequate remuneration.

The public's interest in the plans is that they should provide the most benefits for the least cost, consistent with financial soundness, good administration, and fair remuneration to hospitals. It is a decidedly short view which would have it that the plans can benefit by underpaying hospitals.

In summary, while there are certain conflicts of interest, on the whole there is a large measure of identity of interests on the part of all concerned. All agree that service to the public is the real aim. All agree on the principle that hospitals should be fairly remunerated. Any differences tend to be confined to the technical point of what constitutes fair remuneration. The substantial identity of interests of all participants undoubtedly explains why it is that different plans, some dominated by lay persons, others by hospital administrators, still others by physicians, seem to behave in very much the same way.

The plans then are controlled by persons who wish to see the plans succeed. Success means benefits to the public and is largely measured in terms of people enrolled. Those in control tend to do those things which will make the plan most successful. The plan becomes an entity in itself, the success of which is forwarded by certain moves, held back by others.

The plan must on all counts remain solvent. Support of the hospitals is necessary, so the plan does what is necessary, consistent with other objectives, to win the support of hospitals. The same is true as regards the medical profession. The plan needs the good will of large employers because these make the plan available to their employees and influence other employers to do the same. Where labor organizations are strong, the plan will reach out for the support of these organizations, possibly by putting a representative of labor on the board. For the plan to be of maximum success it must give the general public the feeling that the plan belongs to the public, that it is in truth a civic organization, of, by and for the public. The endeavor to do this tends ultimately to be reflected in the control of the plan.

In the field surveys, an endeavor was made to determine what groups or persons really controlled the plan, i.e., to go behind the nominal representation of various groups on the board of directors. This type of appraisal is not easy, especially in a short visit. Naturally main reliance must be

placed upon information provided by the plan director, who in some cases may be biased and in other cases may not correctly evaluate the role played by key figures on his board.

Of the 39 plans visited, it seemed to the surveyors that 16 plans were in reality controlled by the "public", i.e., by lay persons whose sole or dominant aim was benefit to the public. In a considerable number of cases, these lay persons were hospital trustees. Six of the plans surveyed seemed to be firmly controlled by the hospitals. Largely these were plans in which the hospital representatives on the plan boards were entirely or mainly hospital administrators. Three plans seemed to be jointly controlled by hospitals and the public representatives, three plans seemed to be controlled by the plan director. In one of these cases the plan director seemed to give undue consideration to his own interests, at any rate he was paid a salary out of line with the salaries paid the directors of other plans with comparable membership. In the other two cases, the directors apparently ran the plan for what they conceived to be the public's interests. Two plans seemed to be dominated by the plan director and the medical profession; two other plans, by the hospitals and the medical profession jointly. In two instances, control of the plan seemed to be pretty well diffused among hospital, medical and public representatives. In the case of the five remaining plans, no definite decision could be made as to where control really lay.

It has been largely assumed that hospital service plans are controlled by the hospitals. The truth seems to be that more often they are controlled by persons who think of themselves as representing the public.^{8/}

WHO SHOULD CONTROL THE PLANS?

Among executive directors and board members there seems to be two theories as to which groups or interests should control the plans. One theory runs to the effect that the plan is simply a projection of the hospitals, that it is an agency of the hospitals for selling or providing their services to the public. This view naturally holds that hospitals should have dominant control of the plan.

The second theory is that the plan is a civic enterprise, that it is an agency of the public rather than of the hospitals. This view holds that the plan should be independent of the hospitals, and that since the aim of the plan is service to the public and since the public foots the bill, dominant control should lie with the public.

The question of which of these views is the more correct depends perhaps upon the stage of development of the plan. A new plan which hospitals have started and which they underwrite is in a very real sense a creature of the hospitals. However, as the plan grows it stands more and more on its own feet. As it accumulates a reserve the underwriting burden is lifted from the hospitals and is shared between the plan and the hospitals. As the number of subscribers grows public interest in the plan intensifies. After a certain stage it would seem that dominant control should shift to the public.

Perhaps the relationship of parents to children supplies a good analogy here. When children are young parents should control them. When the children have grown, when they support themselves, then parental control is neither desirable nor possible.

^{8/} It is of interest in this connection that in addressing the plans at the April 1947 conference Mr. Hayes, president of the American Hospital Association, stated that from the standpoint of hospitals Blue Cross had two failings, first that plan payments to hospitals had not kept pace with hospital costs, and secondly that the plans did not have a sufficient proportion of hospital people on their boards -- people who knew hospital costs and were familiar with hospital problems.

CHAPTER 9

ADMINISTRATIVE ORGANIZATION AND PROCEDURES

Most hospital service plans have three main departments: an enrollment department, which enrolls new subscribers; a record-keeping department, which bills subscriber groups and subscribers for the subscription charges, maintains records of subscribers eligible for care, and keeps the accounts of the organization; and a hospital department, which confirms to the hospitals the eligibility of subscribers for hospital care and pays the hospitals for care provided to subscribers. Many plans have two other departments which report directly to the executive director, a public education or publicity department, which handles publicity, gets up the promotional or enrollment literature of the plan and aids on public relations; and a statistical or research department, which compiles reports on hospital utilization, actuarial experience, and the like.

Another way of indicating the administrative organization of the plans would be to say that the operation of a plan entails a number of functions. These are: enrollment, billing, maintenance of subscriber records, confirmation of hospital eligibility, payment of hospitals, accounting for funds, public education and statistical analysis. These functions can each become the basis of a separate department. In most plans they are, however, grouped in the three main and two subsidiary departments indicated above.

ENROLLMENT

The function of enrollment includes (a) the enrollment of new groups, and (b) the enrollment of additional subscribers in existing groups.

The enrollment of subscribers in new groups entails explanation of the plan by the enrollment representative to the employer, persuading the employer to make the plan available to his employees, the distribution of literature to the employees, explanation of the plan to them either in groups or individually, and securing from as many as possible a signed application blank.

The enrollment of new subscribers in existing groups consists of making arrangements with employers for enrollment of new employees within a certain period of their acceptance of employment, and for holding re-enrollments within the group. The enrollment of subscribers in existing groups tends to be more of a routine 'service' function than the 'selling' of new groups, and some plans have seen fit to assign the two functions to separate units within the enrollment department.

BILLING AND RECORD KEEPING

The application cards from newly enrolled subscribers go to the billing and record keeping department which issues to the subscriber a contract and an identification card. Almost all of the plans use business machine equipment, and there is now punched from the application card a billing card, which gives the name of the subscriber, his group and contract number, the type of contract which he holds, (i.e., semi-private or ward, and single person, hus-

band and wife, or family) the monthly charge, and such other data as the plan may wish to include for billing or statistical purposes. The billing cards are usually filed alphabetically by groups, and the application cards are usually filed in the same manner in an adjacent file.

The billing cards are then run each month to produce the group bill, two copies of which are usually sent to the employer, who keeps one and returns the other with his remittance. If an employee leaves the concern or cancels, his card is removed from the group billing file so that this file always maintains a record of paid up subscribers in this group.

Many plans assign a certain number of subscriber groups to so-called "units" consisting of two or three clerks. The personnel of each unit is responsible for maintenance of the records for its groups, for getting out the billings, for taking care of transfers between groups, or of changes in the type of contract held by a subscriber, and for all relations with their firms and with subscribers in these groups. The unit is also responsible for the certification of the paid up status of the subscriber in the case of a hospital admission. The unit system decentralizes the files of subscriber records and centralizes responsibility for a certain group of accounts upon one or more persons.

Many plans, in the case of very large firms, have discarded the so-called positive method of billing (in which the bill lists each subscriber-employee with the amount due from each) in favor of what is known as negative billing. Under this system the firm and the plan each maintain a file of current subscribers, but the plan sends no detailed monthly listing to the employer. Instead the employer supplies the plan with changes made (employees added, dropped, changes in types of contracts made, etc.) in such manner that a complete reconciliation between the previous month's remittance and the current month's remittance can be made. This procedure has been found to be a saving for both the plan and the employer.

Pay direct subscribers are handled by separate units. Generally the cards for these subscribers are placed in separate groups depending upon whether payment is made quarterly, semi-annually or annually. At the appropriate time the cards are run to produce bills, much like utility bills, which are then mailed to the subscribers. The subscriber detaches the stub and returns it with his remittance.

CONFIRMATION OF HOSPITAL ELIGIBILITY AND PAYMENT OF HOSPITALS

When a member is admitted to a hospital he presents his identification card and gives to the hospital admitting clerk such data as the plan may require in order to identify him or her as an eligible subscriber. The hospital then sends to the plan an admission notice, giving this and other required data such as the admitting diagnosis and name of doctor. These admission notices are received in the hospital department and are routed to the appropriate units for the subscribers in question. The clerk in the unit verifies the subscriber's paid up status and indicates on the notice whether the person is entitled to care and the number of days (remaining over from any previous admission) to which he is entitled. The clerk will also post on a card or jacket affixed to the application card the name of the person admitted, the date of admission, and a code number for the hospital. A copy of the admission notice with liability for the case accepted or rejected is then returned to the hospital.

When the patient is discharged, the hospital makes out a bill for the case. This gives the date of admission and discharge, the number of days charged for, the hospital's regular charges for the services rendered, and the amount the hospital is entitled to at the rates of payment provided by the plan. This bill is matched with a copy of the admission notice and checked for correctness. The bill is then sent to the appropriate unit where the date of discharge and number of days used is posted onto the subscriber's service record. A hospital claim punched card is then made from the bill. This card is used in preparing the voucher, listing the cases paid for, which accompanies the plan's check to the hospital. Most plans pay their hospitals once a month.

A number of plans follow a somewhat different procedure in determining the number of days for which a subscriber is eligible. The admission notice is forwarded to the unit which enters on the subscriber's service record a claims number. A punched card is then made for the hospital admission, this card being completed when the hospital bill is received. A record of these claims may then be run off which is consulted when any new hospital admission is received for this subscriber in order to ascertain the number of days for which he is still eligible. Alternatively the claims records are filed alphabetically and this file is inspected to ascertain any previous admissions during the year for the member in question and the number of days used.

These are the main operations which must be performed in the administration of a hospital service plan. Probably no two plans perform all of these operations in exactly the same way, but the essential principle is the same.^{1/}

^{1/} An important administrative innovation is so-called blanket coverage of dependents. This procedure was first instituted by the Buffalo plan; it is now used by some seven or eight plans and will probably be widely adopted. Under this procedure the plan maintains no current record of the dependents of a subscriber. It authorizes hospital care for any eligible dependent of a subscriber (who has family coverage), on the basis of data on the hospital admission notice.

This procedure eliminates much costly record keeping. Since no record of the names of dependents is maintained no change of record must be made when there is a change in a subscriber's dependents, e.g., spouse dies or is divorced, a child is added or a child reaches the upper age limit and is dropped. No system for tagging the latter children as they reach the age limit needs to be maintained. In a large plan the volume of these changes is enormous and they are costly to make. (The Buffalo plan estimated that each such change used to cost it 60 cents.)

Under this arrangement the plan does not have a detailed count of the number of dependents; however, this can be approximated through spot checks. Experience indicates that there are no drawbacks from the standpoint of possible fraudulent admissions. The method has the great advantage that it facilitates coverage of new born infants from the first day. Blanket coverage is only feasible under a dual rate structure.

CHAPTER 10

THE FINANCES OF HOSPITAL PLANS

Blue Cross is "big business". At the end of 1945 the 80 approved plans in this country had total assets of \$80,311,953, liabilities of \$32,292,617 and reserves of \$48,019,336. As expected, a large part of this money is concentrated in a few plans. The 12 plans with over 500,000 participants had total assets of \$50,791,944 and reserves of \$30,067,661.

The total income of the 80 plans in 1945 was \$123,333,241. From this income \$100,654,286 or 81.6 percent was paid to hospitals, \$11,990,598 or 12.2 percent was used for administration and \$7,688,357, 6.2 percent, went into reserves.

The distribution of income during the past six years has been as follows:^{1/}*

<u>Year</u>	<u>Hospitalization Expense</u> %	<u>Administration</u> %	<u>Additions to Reserves</u> %
1945	81.6	12.2	6.2
1944	76.5	12.3	11.2
1943	75.9	12.3	11.8
1942	74.8	12.1	13.1
1941	70.6	12.3	17.1
1940	74.0	13.8	12.2

It will be seen that since 1941 the proportion of income used for hospitalization has increased, while the percentage of income added to reserves has dropped. The 1945 distribution of income probably is somewhat abnormal. Because of rapidly rising hospital costs many plans found it necessary to increase their rates of payment to hospitals. A good many of these plans did not immediately raise their rates to subscribers but for a certain period financed the increased payments by dipping into reserves. As a result 13 of the plans had a net deficit for the year and many others had an uncomfortably small margin of net income. Appendix H gives the salient financial data for each of the plans.

As might be expected there is great variation among the plans in the proportion of income used for hospitalization, administration, and additions to

^{1/} Plans in the United States only.

* As this report was being prepared for press, 1946 financial data for the plans became available. In 1946 the plans (United States only) had a total income of \$168,602,501. Hospital expense amounted to \$135,157,308 (82.6%), administrative expenses amounted to \$21,249,712 (13.0%) and additions to reserves, \$7,195,481 (4.4%). Total reserves at the end of the year amounted to \$56,545,616. The data for the individual plans are set forth in Appendix I.

reserves. Thus in 1945 (considering only plans in operation more than three full years) the percent of income used for hospitalization varied from 59.1 for the Sacramento plan to 103.3 in the case of the Akron plan. The percent used for administration varied from Akron's 6.5 to Durham's 29.3^{2/}. The percent of income added to reserves varied from a deficit of 9.8 for the Akron plan to 26.7 for Maryland.

Two factors which exert some influence on the distribution of a plan's income among hospitalization, administration and additions to reserves, are the age and the size of a plan. Administration costs, for obvious reasons, are relatively high during the plan's first two or three years. (In the first few months of operation, administrative expenses often exceed income.) Hospital expense tends to be low during this initial period, chiefly because of the maternity waiting period. After two or three years hospital and administrative expense ratios tend to be stabilized and from then on it is the size, rather than the age of the plan, which influences these ratios.

The size of a plan appears to exert a definite influence on the proportion of income used for administration. As indicated in Table 9 the larger plans use an appreciably smaller proportion of income for administration than do the smaller plans. There does not seem to be any clear relationship be-

TABLE 9			
Distribution of Income by Size of Plan, 1945.			
(Does not include plans in operation less than three full years)			
SIZE GROUP NO. OF PARTICIPANTS	HOSPITAL EXPENSE %	ADMINIS- TRATIVE EXPENSE %	ADDITIONS TO RESERVES %
OVER 500,000 (12 PLANS)	83.6	11.4	5.0
200,000 TO 500,000 (12 PLANS)	78.2	11.6	10.2
100,000 TO 200,000 (23 PLANS)	77.8	14.6	7.6
UNDER 100,000 (28 PLANS)	80.2	14.7	5.1

tween size of plan and proportion of income used for hospitalization, although in both 1945 and 1944 the largest plans -- those with over 500,000 participants -- used more of their income for hospitalization than any other size group.^{3/}

FACTORS AFFECTING THE HOSPITALIZATION EXPENSE RATIO

Table 10 shows the distribution of plans according to proportion of income used for hospitalization. What factors are responsible for the wide variation?

2/ Not counting the New Mexico plan (1945 administrative expense ratio 52.8 percent) which although in operation as a local plan for several years was reorganized as a state-wide plan and first approved in 1945.

3/ In 1944, the proportion of income used for hospitalization by the plans of different size groups was as follows (plans in operation less than three full years excluded): Over 500,000 participants, 78.2 percent; 200,000 to 500,000 participants, 76.1; 100,000 to 200,000 participants, 72.5; 50,000 to 100,000 participants, 70.7; and under 50,000 participants, 73.0.

TABLE 10	
Distribution of Plans According to Proportion of Income Used for Hospitalization, 1945 (Does not Include Plans in Opera- tion Less than Three Full Years)	
PERCENT RANGE	NUMBER OF PLANS
UNDER 60.0	1
60 - 64.9	1
65 - 69.9	7
70 - 74.9	9
75 - 79.9	21
80 - 84.9	17
85 - 89.9	10
OVER 90	8
TOTAL	74 ^{1/}
1/ Excludes New Mexico plan. See footnote 2.	

The plan's per diem payments to hospitals, the duration of benefits, and the hospital utilization rate among its subscribers, determine the amount of hospitalization expense. A plan's subscription rates affect the ratio of this expense to income. If two plans spend the same amounts per subscriber for hospitalization but one has more income per subscriber than the other, the first will have a lower hospitalization expense ratio than the second.

The proportion of its income that a plan utilizes for hospitalization expense or for additions to reserves depends in part upon circumstances but in the long run reflects very largely the policy or philosophy of the plan. Naturally these proportions are affected by the percent of income which the plan has to use or chooses to use for administration. In any particular period a plan may use for hospitalization a higher or lower proportion of its income than it had counted on, owing to hospital utilization or per diem costs of hospital care, being higher or lower than had been anticipated. But in the long run a plan tends to adjust its rates, its subscriber benefits or its payments to hospitals so that the proportion of income used for hospitalization or, conversely, added to reserves, more or less reflects conscious policy.

The plans have pursued different policies in this regard. Some, as for example the Michigan plan, which over the three years, 1943-5, used 88.7 percent of income for hospitalization and only 1.4 percent for reserves, have thought it best to keep reserves at a minimum and to return to the subscriber in current benefits as large a proportion of his subscription dollar as possible. Other plans, with the same social motivation, have preferred to steer what they regarded as a safer course. At the opposite extreme are plans like the Sacramento plan, (which in the years 1943-5 has put 56.3 percent of income into hospitalization and 18.9 into reserves) which have probably retarded their growth by returning so little in benefits to their subscribers.

The policy pursued in this regard very largely reflects the temperament of the plan's director and the leading figures on the board. It reflects also the degree of backing given by the plan's hospitals. A plan which is firmly underwritten by its member hospitals can afford to have less reserves than one which is not underwritten by its hospitals and must depend solely on its own reserves for financial security. The policy pursued also reflects past experiences. The New York plan was "burned" by its experience in 1939 and for several years thereafter pursued a quite conservative policy.

FACTORS AFFECTING ADMINISTRATIVE EXPENSE RATIOS

In the aggregate the plans use 12.2 percent of income for administration. But the variation in this regard, as Table 11 shows is great. One mature plan operated on less than 7 percent of income, while 5 plans (over three years old) used over 20 percent of income for administration. What is the explanation of this variation?

TABLE 11	
Distribution of Plans According to Percent of Income Used for Administration, 1945 (Does not include plans in operation less than three full years)	
PERCENT RANGE	NUMBER OF PLANS
UNDER 7.00	1
7 - 9.99	12
10 - 12.99	29
13 - 15.99	11
16 - 18.99	12
19 - 21.99	5
22 - 24.99	2
25 - 27.99	1
28 - 30.99	1
TOTAL	74 ^{1/}
^{1/} Does not include New Mexico plan. See footnote 2.	

One quite important factor is the plan's rates and benefits. Some plans provide predominantly ward care or give only partial benefits to subscribers, and their subscription rates are correspondingly lower than those of other plans. Yet these plans must go through practically the same administrative procedures -- the enrollment of new subscribers, the keeping of subscriber records, paying hospitals, etc., as the plans with greater benefits and higher income per subscriber. The cost of performing these administrative procedures, in terms of dollars and cents per subscriber per year, is about the same whatever the dollar value of the benefits provided. The result is that plans with restricted benefits and low rates tend to show higher administrative expense ratios than plans with comprehensive benefits and high subscription rates.

That percent of income used for administration and annual cost of administration per subscriber do not necessarily go together is shown by the data of Table 12. It is evident that a low administrative cost ratio is not in itself an index of administrative efficiency. It may simply indicate that the plan has a relatively high income per subscriber. In some respects administrative costs per member are a better index of high or low cost of administration.

In part, therefore, the variation in administrative expense ratios among the plans may simply reflect differences in income per subscriber. In part the variation is due to differences in managerial talent among the plan directors -- some plans are administered more efficiently than others. The size of the salaries which the plan chooses to pay affects administrative cost, and some plans pay more than others for about the same talent. A few plans are

TABLE 12		
Comparison of Administrative Expense Ratios and Annual Administrative Costs per Subscriber for a Number of Plans, 1945.		
PLAN	PERCENT OF INCOME USED FOR ADMINISTRATION	ANNUAL ADMINISTRATIVE COSTS PER SUBSCRIBER ^{1/}
	%	\$
CLEVELAND, OHIO	7.0	0.46
RHODE ISLAND	8.8	0.61
COLORADO	10.1	0.59
MICHIGAN	10.5	0.77
MINNESOTA	11.1	0.59
KINGSFORD, TENN.	11.2	0.55
ROCHESTER, N. Y.	11.5	0.80
SAVANNAH, GA.	11.9	1.03
DELAWARE	12.0	0.76
NORFOLK, VA.	12.0	1.09
NEW YORK, N. Y.	12.9	1.07
OAKLAND, CALIF.	16.2	1.77 ^{2/}
ASHLAND, KY.	18.7	1.01
LOS ANGELES, CALIF.	19.0	1.75 ^{2/}
CHAPEL HILL, N. C.	19.4	1.10 ^{2/}
^{1/} Administrative expenses for the year divided by the average of the number of participants at the beginning and end of the year. Appendix H gives this information for each plan. ^{2/} These plans issue both hospital and medical contracts, and the costs shown include administration of both contracts.		

subject to taxes from which other plans are exempt. Thus the plans in California all must pay a 2-1/2 percent premium tax. The type and size of the area served makes a difference. A plan which serves a large, sparsely settled area will, other things being equal, have far higher costs for travel, telephone, etc., than a plan which serves a densely populated metropolitan area.

Acquisition costs in some plans are a very large part of all administration costs, and these costs vary greatly from plan to plan. Figures for a few plans for which these data are available are presented:^{4/}

Plan	Acquisition Expense (% of Income)	Administrative Expense other than for Acquisition (% of Income)	Total Administrative Expense (% of Income)
Rochester	1.4	9.4	10.8
Alabama	4.6	10.3	14.9
Texas	6.3	14.2	20.5
Sacramento	9.5	14.4	23.9
Huntington	11.3	11.4	22.7
Chapel Hill	8.3	11.9	20.2
Durham	14.8	11.0	25.8
Kansas	7.1	10.1	17.2
Delaware	3.2	14.4	17.6
Massachusetts	2.4	9.2	11.6

^{4/} The data are for either 1943 or 1944. This sample is defective in that it includes an unduly high proportion of plans with high administrative costs. For the plans as a whole acquisition costs probably run at about 2 to 3 percent of income.

It is apparent from these figures that differences in acquisition expenses account for a considerable part of the variation in administrative costs among plans. Acquisition costs, as a percent of income, are especially heavy in a new plan. They are apt to be far greater for plans serving rural, than for those serving urban areas. They will be greater where the average size of enrolled groups is small than where it is large.

The size of a plan affects administrative expense. In general the larger plans use a smaller proportion of income for administration and have a smaller administrative expense per member than do the smaller plans. That large size seems to make for economy of administration may seem to be belied by the fact that there are a considerable number of small plans with quite low administrative expenses per member and administrative cost ratios. However, with few exceptions these plans serve a very restricted area and they have had for years a very slow growth. In some cases these small plans appear to have achieved low operating costs by economizing on enrollment efforts.

Why is it that the smaller plans do not appear to be able to operate as cheaply as the larger ones? In part it is due to the fact that the plans must incur certain fixed or overhead charges and these charges, at least up to a certain point, do not increase proportionately with the size of the plan. Thus in 1944, the salary of the director of the smallest plan amounted to 9.4 percent of that plan's total income, whereas the very much greater salary of the director of the largest plan amounted to but 16/100's of one percent of that plan's income. The plans must incur expense for office rent, telephone, light, etc., and these expenses tend to be proportionately greater for a small than for a moderate sized plan, though after a certain size is reached these expenses probably increase more or less proportionately. If a small plan uses mechanical tabulating equipment, the expense for this equipment will remain fixed regardless of number of members until the plan reaches that size at which additional equipment is needed. The smaller plans cannot achieve the full advantages of specialization; they cannot afford, as do the larger plans, to have one person assigned to publicity, another to hospital relations, etc. Small plans tend to have less prestige and secure less publicity than larger ones, simply because they are small.

The administrative expenses of the Durham plan (29.3 percent in 1945) are so far out of line as to call for special note. Primarily the explanation lies in the fact that this plan in addition to its regular contracts offers an "industrial insurance" type of contract. These latter contracts are sold on a commission basis by agents who collect the premiums weekly. Acquisition and administrative costs on these contracts run close to 50 percent. The plan's defense of these contracts is that they enable it to reach low income subscribers who could not be reached on any other basis.

In considering administration costs it should be borne in mind that a low administration expense ratio or a low cost of administration per subscriber do not necessarily indicate efficient administration. Efficient administration is indicated both by cost of administration and the results of administration -- the latter probably being best reflected in the growth of the plan. Some plans have achieved a low cost of administration by employing few enrollment representatives. Still others have achieved a low cost by skimping on certain services which in the long run are necessary for intelligent operation of the plan. The efficiently conducted plan is one that has a good record of achievement and a low cost of administration.

RESERVES

The following figures show the distribution of plans according to percent of net income, i.e., percent of income added to reserves. Both 1945 and 1944 figures are given since the 1945 experience, for reasons previously indicated, is probably abnormal.

Percent of Income Added to Reserves	Number of Plans	
	1945	1944
Deficit	13	3
0.0 to 5.0	21	9
5.1 to 10.0	24	19
10.1 to 15.0	11	21
15.1 to 20.0	7	11
20.1 to 25.0	3	8
25.1 to 30.0	1	2
Total	80	73 ^{1/}

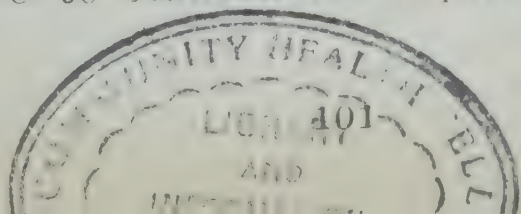
^{1/} Data for 3 plans not available.

The reasons for the variation among the plans have to some extent already been dealt with. From one point of view, additions to reserves may be thought of as the residual after hospitalization and administrative costs have been met. Perhaps, however, it is more realistic to view additions to reserves as a determining factor: in the long run the plan decides what margin of net income it wants and then adjusts its rates and benefits so that it will have this net income. Ordinarily a plan will try to put into reserves in any current period the amount required in order gradually to build reserves up to or maintain them at, the level the plan believes is desirable.

At the end of 1945 the plans had aggregate reserves equal to \$2.54 per participant and sufficient to meet hospitalization expense for 5.3 months for the then current number of participants (See Appendix H). Table 13 shows the distribution of the plans according to reserves per participant and reserve-months of hospitalization. Some plans it will be seen have almost no reserves -- one plan which has been carried by its member hospitals is in debt to them. On the other hand, there are a few plans with reserves sufficient, without further income, to provide hospitalization to the then current number of subscribers for over a year.

What is an adequate reserve? This depends on a number of factors. It depends first and foremost upon whether the plan is firmly underwritten by its member hospitals and upon whether or not they are willing in effect, to make temporary loans to the plan to carry it over any period in which expense exceeds income. For example, when the manager of the Kansas plan was employed he was told by his board that they wanted the plan run without large reserves. In other words the hospitals not only agreed to guarantee the benefits but they were ready, if need be, to take fluctuating payments in order to permit the plan to pay out close to 100 percent of current income in benefits and administration.

The hospitals of most plans contractually agree to underwrite the plan, but generally they want the plan run so that they can count on steady and assured payments, in other words so that the possibility of their having to make good on their guarantee of benefits will be a remote contingency. Hence the plan needs a reserve to cushion the impact of any temporary unfavorable



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TABLE 13

Distribution of Plans According to
(A) Dollar Reserves per Participant, and
(B) Number of Reserve-Months of Hospitalization,
December 31, 1945

(Does not Include Plans in Operation
Less than Three Full Years)

A. Dollar Reserves per Participant		B. Reserve Months of Hospitalization	
DOLLAR RESERVES PER PARTICIPANT	NUMBER OF PLANS	RESERVE-MONTHS OF HOSPITALIZATION ^{1/}	NUMBER OF PLANS
\$ LESS THAN 0.00	1	(month) LESS THAN 0	1
.00 - .49	4	.0 - 0.9	4
.50 - .99	8	1.0 - 1.9	6
1.00 - 1.49	11	2.0 - 2.9	9
1.50 - 1.99	8	3.0 - 3.9	6
2.00 - 2.49	14	4.0 - 4.9	8
2.50 - 2.99	7	5.0 - 5.9	10
3.00 - 3.49	5	6.0 - 6.9	4
3.50 - 3.99	7	7.0 - 7.9	7
4.00 - 4.49	2	8.0 - 8.9	7
4.50 - 4.99	1	9.0 - 9.9	3
5.00 - 5.49	2	10.0 - 10.9	1
5.50 - 5.99	3	11.0 - 11.9	2
6.00 - 6.49	1	12.0 - 12.9	2
6.50 - 6.99	1	13.0 - 13.9	2
TOTAL	75	TOTAL	72 ^{2/}
<p>1. Average monthly hospitalization expense per participant times the current number of participants divided into total reserves. Specifically, the figures for each plan (See Appendix b) were obtained by dividing the average number of participants during the year (average of number of participants at the beginning and end of the year) into one-twelfth of the year's total hospitalization expense. The result multiplied by the number of participants on January 1, 1946 was divided into total reserves as of that date.</p> <p>2/ Full data not available for three plans.</p>			

experience and to prevent this experience resulting in reduced payments to hospitals.

At the other extreme are plans, such as the Sacramento and Oakland plans, which are not underwritten by the member hospitals (such was the situation at the time of the survey visit) and where these hospitals really undertake no obligation whatever to the plan. These plans have to stand entirely on their own financial legs. Hence they maintain large reserves -- \$6.78 per participant in the Sacramento plan, \$5.58 in the Oakland plan.

The reserve needed by a plan also depends upon its ability to make adjustments quickly -- upon whether or not it can change the subscription rates and benefits on short notice. Some plans have subscriber contracts which run for a year's period, and the plan can only change the subscription rates and benefits at the expiration of the contract. Such a plan, when it determines that a change in rates or benefits is necessary, can only make the change

gradually over a year's period -- replacing each subscriber's contract as it expires. These plans need more reserves than the vast majority of plans which can change subscription rates and benefits on short notice or without notice. (As of July 1945, three-fourths of the plans had contracts which could be cancelled or revised on 30 days notice or less, and the whole trend has been in the direction of such provisions, as opposed to contracts which can only be cancelled or revised at the end of the contract year.)

A plan which is at liberty to change its contracts on 30 days notice or less could institute a rate change in two to four months, i. e., it would require this period of time to inform all subscriber groups of the change, reenroll subscribers at the new rate (when this is necessary), change its billing cards, etc.

The contingencies against which a plan needs or might seem to need reserves are the following: (a) sudden increase in hospital utilization owing to a public disaster or epidemic; (b) sudden increase in utilization owing to various other contingencies; (c) unanticipated increase in per diem hospital costs; (d) gradual increase in hospital utilization owing to changes in medical practice, greater tendency of the public to seek hospital care, etc.

Any conceivable public disaster would probably entail but a small over-all increase in hospital utilization. This is so because the need for hospitalization owing to such a disaster would probably exist only for a few weeks following such a disaster, and because the amount of care which could be provided in regular hospitals is limited by existing hospital capacity. Hospitalization in emergency facilities would probably be provided by public authorities at no cost to the patient or the plan. A plan which served a whole State or a large metropolitan area would probably feel the consequences of a public disaster less than one which served but a small community.

Possible increases in hospitalization due to an epidemic tend to be limited by the following facts: (a) certain types of infectious disease cases are ordinarily not admitted to general hospitals, (b) hospital capacity at any one time is limited and an increase in admissions of epidemic disease cases is apt to be offset by a decrease in admissions of other cases, and (c) an epidemic in any one community is not likely to last more than a few months. An epidemic which filled all hospitals in a community to 110 percent of normal capacity for three months would probably result in excess hospitalization expense to a plan equal to between 1½ and 2 months' normal utilization.

No epidemic in recent years in this country has resulted (so far as we have been able to ascertain) in any appreciable over-all increase in hospital utilization. Epidemics of infantile paralysis, typhoid, meningitis, etc., which may receive considerable newspaper publicity at the time have not been important from a hospital utilization standpoint since the number of cases has been negligible in comparison with the ordinary hospital admissions. While the influenza outbreak of the winter of 1943-1944 resulted in an increase in the percentage of admissions of influenza and pneumonia cases from an ordinary level of 5 percent to a peak in December 1943 of 18 percent, it did not result in any increase in total admissions. In fact the over-all admission rate was less in December 1943 than in December 1942 or 1944.

A plan needs a reserve against various other contingencies which might suddenly increase hospital utilization rates. Thus utilization might be increased because of unsound enrollment methods, by provision of greater benefits, the addition of a medical plan, greater availability of hospital facilities, etc. (Since the war the plans have experienced an increase of 10 percent or so in hospital utilization rates.) It has been factors of this sort

and increases in per diem costs of hospital care, not epidemics, which have been responsible on past occasions when plans have gotten into difficulties.

A reserve is necessary to give a plan time to revise its rates in case of an increase in per diem hospital costs. The reserve for this purpose will need to be larger in a period of unsettled economic conditions, when price levels are rapidly changing, than in a period of relatively stable prices. A plan which pays its hospitals on a regular charge basis, with no control over increases in charges, will of course need far larger reserves than one which pays its hospitals on a fixed per diem basis. If the plan's contract with hospitals holds for a specified period, say, a year or six months, then a plan which pays its hospitals on a fixed per diem basis need maintain only small reserves against increasing hospital costs. If negotiations with hospitals result in a sizeable increase in per diem hospital payments, the plan will have had adequate notice and can institute an increase in subscription rates to compensate.

It would not seem necessary or desirable for a plan to maintain reserves against the long run effects of gradual upward trends in hospital utilization rates owing to increasing age of the population, changes in medical practice, greater tendency on the part of the public to use hospitals, etc. Increased utilization due to such developments can be taken care of by rate revisions in due course. But a plan does need reserves to give it time to institute rate revisions as the short run effects of these trends become manifest.

It should be emphasized that in these hospital service plans the purpose of a reserve is not to guard against future long time contingencies but rather to give the plan a "breathing space" in case of the development of an unfavorable experience -- to give it time to adjust its rates, benefits or payments to hospitals so as to regain a sound basis.

As a yardstick for the purpose of appraising the adequacy of present reserves let it be assumed that a plan which has been putting 5 percent of income into reserves suddenly experiences an increase in hospitalization expense of, say, 25 percent and finds itself with a deficit of 15 percent of monthly income. A plan with reserves equal to 35 percent of current annual income -- which was the approximate situation of all the plans together at the end of 1945 -- would have 28 months in which to assess the causes for the development and make the necessary adjustments, i.e., cancel out the unsoundly enrolled groups, revise subscription rates or benefits, or hospital payments. Assuming developments resulting in a deficit of 30 percent of monthly income, a plan with reserves equal to 35 percent of current annual income would have 14 months to make the necessary adjustments.

In 1942 the Blue Cross Commission recommended that plans maintain reserves equal to five times monthly income or seven times monthly hospital expense, whichever was the greater.^{5/} In the 1946 revision of the American Hospital Association's standards of approval it was specified that plans, in the absence of hospital-responsibility for contract benefits, should maintain reserves equal to 25 percent of current income. Both of these standards - the latter, of course, is a minimum - seem reasonable in the light of current knowledge. At the end of 1945 the plans, with reserves equal to 5.3 months of hospitalization, were maintaining less reserves than the Commission had

^{5/} For the basis of this recommendation see, Norby, Maurice, J., *Blue Cross Contingency Reserves: Their Amount and Adequacy*, Hospitals, March, 1942.

earlier recommended. However, with aggregate reserves equal to approximately 35 percent of current annual income they were well above the minimum standard quite apart from the factor of hospital guarantee of benefits.

FINANCIAL SOUNDNESS OF THE PLANS

It is obvious that most hospital plans are in a strong financial position. Not only are most -- two-thirds -- of the plans contractually underwritten by their member hospitals, but most plans have reserves which would seem to be adequate to provide against all possible contingencies, quite apart from the backing of their member hospitals.

However, it is equally obvious, as an examination of Appendix H will show, that certain plans do not share this strong position. For example, at the end of 1945 there were seven plans -- Montana, Florida, Washington, North Dakota, Kansas, Indiana and Michigan -- which had reserves equivalent to less than one month's hospitalization expense. Unless these plans were firmly and contractually underwritten by their member hospitals, they were in a weak financial position. Of these plans, three -- Michigan, Kansas and Washington -- were visited during the survey and were found to be contractually underwritten by their member hospitals. Copies of their hospital contracts (as of January 1947) have been obtained from the other four plans. All four plans are definitely and firmly underwritten by their member hospitals.

An examination of the financial position of the individual plans also shows that some plans have piled up reserves beyond need. These plans have carried caution to excess. It may be seen that some of the plans with the largest reserves have a relatively poor enrollment record. By charging relatively high rates or giving relatively small benefits they have presented a less attractive proposition to the public than other plans and the public's response has been correspondingly less enthusiastic.

ARE THE PLANS GENUINELY NON-PROFIT?

The plans declare themselves to be non-profit organizations. Is the actual operation of the plans in accordance with their declared character? In practice is there any tendency for those in control of the plans to use them for their private profit? Is there any tendency for the managerial staffs of the plans to be paid salaries which are inconsistent with the non-profit character of the plans?

In the course of the survey no audits of plan finances were made; the financial statements prepared by the plans were depended upon. In no instance among the 39 plans surveyed was there any reason to question the fundamental non-profit character of the plan. A few instances were observed in which directors of plans secured some remuneration or advantage from the plan. In two instances -- perhaps there are others -- a member of a plan's board served as legal counsel for the plan and was paid for his services. This fact was known to all the other members of the board and quite probably the legal services provided were worth many times what the plan paid for them. In a number of instances plans had funds on deposit with banks of which an official was a member of the plan board. Here again this fact was known to the other members of the board. In some of these cases the plan had funds on deposit with practically every large bank in the city and not to have used the bank in question would have constituted a discrimination. In some instances

the plan was using this particular bank before the officer in question became a director of the plan. It is not suggested that any of the instances cited were improper. Situations of this sort however do point to the need of the plans to formulate what might be termed codes of ethics governing cases in which there are or may be financial relationships between the plan and individual members of its board.^{6/}

Complete data on the salaries of plan directors were not obtained. However, the following table showing the salaries (at the time of the survey visit) of the directors of certain of the surveyed plans, classified according to size, probably gives a representative picture.

TABLE 14					
Salaries of Plan Directors (At time of survey visit - March 1944 - February 1945)					
AMOUNT OF SALARY	SIZE OF PLAN (Number of Members)				
	OVER 500,000	200,000 TO 500,000	100,000 TO 200,000	50,000 TO 100,000	UNDER 50,000
\$20,000	1				
15,000	2				
12,000 to \$14,000	3	1			
10,000			2		1
9,000 to 9,999	1		2		
8,000 to 8,999				2	
7,000 to 7,999		3	1	3	
6,000 to 6,999		1	1	2	1
5,000 to 5,999			1		1
3,000					1

On the whole the salaries paid to the plan directors seem to be reasonable in view of the responsibilities involved. It is true that there are a few cases where the salary seems to be out of line. Some directors are far better compensated than others considering their ability and the size of their plan. But on the whole it does not appear that the management of these non-profit plans is being unduly rewarded.

^{6/} In at least two instances, the executive directors of plans are members of the board of directors. This may or may not be a desirable practice.

CHAPTER II

CANCELLATIONS

Cancellations, i.e., terminations of subscriber memberships, are an important factor in the operation of Blue Cross plans. In a mature plan with large membership, sizable numbers of new members must be enrolled each month or year solely to offset the steady loss of persons who for one reason or another leave the plan. For example, the Rochester plan in 1943 enrolled 40,000 new persons, lost 20,000 through cancellations, and thus had a net gain in enrollment of only 20,000. The Kansas City plan, to take an extreme example, in 1944 enrolled 30,000 new persons, lost 26,000 old members and made a net gain in enrollment for the whole year of only 4,000. In short, some plans must make strenuous enrollment efforts to 'bail out the boat faster than it is leaking'. Cancellations entail increased enrollment and other administration costs. They also may tend to affect adversely a plan's selection of risks.

The plans do not use uniform procedures in the compilation of statistics on cancellations. Each plan appears to have its own working definition of what constitutes a cancellation. The definitions of the plans differ in detail so that one plan will count as a cancellation what another plan would not consider to be a cancellation.^{1/} For these reasons the present cancellation rates of the plans are probably not strictly comparable. However, the rates, such as they are, do tend to show the magnitude of the problem.

Annual cancellation rates (number of participants cancelled divided by the average number of participants during the year) were obtained for 27 of the plans visited. The lowest rate was 9.3 percent; the highest 30.6 percent; the median rate was 16.0 percent. The distribution of the plans according to their rates was as follows:

<u>Rates</u>	<u>Number of Plans^{2/}</u>
3	
9 - 11.9	6
12 - 14.9	5
15 - 17.9	5
18 - 20.9	3
21 - 23.9	3
24 - 26.9	2
27 - 29.9	2
30 - 32.9	1
All	27

^{1/} For example, the following may or may not be treated as cancellations: a child reaches 19 and is dropped from a family contract; a subscriber dies but his wife and children continue under a family contract; two holders of single contracts convert their contracts into a husband and wife contract.

^{2/} Data are for either 1943 or 1944, mainly the former. In most cases the rate was derived by the rough and ready method of dividing the number of participant cancellations by the average of the number of participants at the beginning and end of the year.

The four plans with the highest rates were the Kansas City (30.6%), Chapel Hill (28.3%), Durham (26.6%), and New Orleans (27.0%) plans. Very high labor turnover in war industries probably accounted for the high cancellation rates in the Kansas City and New Orleans plans. The high rates for the two North Carolina plans may perhaps be explained in part by the fact that both use enrollment agents paid on a commission basis, (a practice which tends to make for high pressure selling). Both of these plans also have special contracts for farm families who are borrowers from the Farm Security Administration and among whom the cancellation rate is very high (in one of the plans 65%).

REASONS FOR CANCELLATIONS

A few plans keep track of the reasons for cancellations. The following are derived from data of the Rhode Island plan for the year 1946:

<u>Reason for Cancellation</u>	<u>Percent</u>
Dropped membership when left group	72.5
Transferred to another plan	1.1
Entered military service	.2
Deceased	1.0
Dropped voluntarily	.4
Dropped for non-payment	21.5
Dependent child reached 19	3.3
Total	100.0

Below are figures from the St. Louis plan:

<u>Reason for Cancellation</u>	<u>Year</u> <u>1942-3</u> %	<u>Year</u> <u>1943-4</u> %
Left employ of concern	59.3	68.0
Left city	1.5	.6
Non-payment	7.8	5.6
Deceased	1.4	1.9
Took another policy	.7	1.1
Military service	20.9	12.8
Miscellaneous	8.4	10.0
All	100.0	100.0

The Philadelphia plan reports the following for the year 1942. This plan does not differentiate between cancellations due to non-payment of subscription charges when a subscriber leaves his place of employment and non-payment under other circumstances.

<u>Reason for Cancellation</u>	<u>Percent</u>
Non-payment of dues	64.0
Suspended for military service	23.5
Merged with another contract	6.3
Subscriber deceased	3.1
Subscriber left Philadelphia area	3.1
All	100.0

It will be seen that a majority of all cancellations occur when a subscriber leaves the employ of the concern where he has been enrolled. Most cancellations, therefore, reflect the shifting of workers from job to job and from place to place. If a subscriber who leaves his place of employment immediately takes a new job with a concern which has a group, he may request transfer to this group, in which case his subscription continues without break. If the new concern does not have a group, the subscriber's membership will lapse unless he chooses to go on "direct payment". Even if the new concern does have a group, a good many subscribers fail to request transfer but let their membership lapse and probably re-enroll when this concern is again re-solicited for members.

When a plan is notified by a concern that the subscription charges for a certain member are not being paid because the subscriber has left its employ, the plan will usually send this subscriber at his home address a notice that membership can be continued by payment of charges directly to the plan, and a bill for the first three months' charges. Usually only about half of those thus solicited pay this first bill and thus go on "direct payment". Among those who do choose to continue membership on this basis, the subsequent rate of cancellation is also high.

The plans report that few subscribers who are on a payroll deduction basis ever request the plan to discontinue their membership or request the concern to cease deducting the charges from their pay. In other words, deliberate cancellation by a subscriber on payroll deduction, because he decides that the plan is no longer worthwhile, is rather rare.

PAST TRENDS IN CANCELLATION RATES

Cancellation rates greatly increased during the war years due to the induction of men and women into the armed services, the increased mobility of the population and the great increase in labor turnover.^{3/} The 1943-1945 rates of most plans were anywhere from 50 to 150 percent higher than these same plans experienced before the war. For example the St. Louis plan reports the following figures:

<u>Year</u>	<u>Percent</u>	<u>Year</u>	<u>Percent</u>	<u>Year</u>	<u>Percent</u>
1936-37	10.2	1939-40	10.2	1942-43	20.9
1937-38	10.0	1940-41	12.5	1943-44	15.6
1938-39	9.3	1941-42	15.4	1944-45	14.4
				1945-46*	17.1
				April 1 - Dec. 31, 1946	10.3

*Fiscal year ends March 31st.

^{3/} The United States Department of Labor reports that monthly separation rates in manufacturing plants in 1939 ranged between 2.6 and 3.5 separations per hundred workers employed. In 1943 the comparable monthly rates were 6.6 and 8.6.

The Delaware plan reports the following:

<u>Year</u>	<u>Contract Cancellations</u> <u>Per Contract Year</u>	<u>Member Cancellations</u> <u>Per Member Year</u>
	(percent)	(percent)
1939	6.2	6.1
1940	6.9	6.7
1941	10.1	9.8
1942	17.5	14.9
1943	17.0	14.7
1944	15.7	14.7
1945	18.7	18.7
1946	14.1	14.3

Cancellation rates reached a peak in the months immediately following V-J day, and have since begun to decline.

CANCELLATION AND LENGTH OF MEMBERSHIP

The rate of cancellations is greatest among new subscribers. Conversely, the longer a subscriber stays with a plan the less likely he is to cancel. This is illustrated by the following figures from the Maryland plan covering the years 1937-8 to 1945:^{4/}

<u>Year of Membership Life</u>	<u>Rate of Cancellations</u> <u>per 100 Member Years</u>
1st year	19.90
2nd year	15.29
3rd year	10.25
4th year	8.27
5th year	6.68
6th year	5.65
7th year	4.32
8th year	3.45
Total	12.61

EFFECT OF CANCELLATIONS ON SELECTION OF RISKS

Data from various plans indicate that cancellation rates are greatest among single subscribers and are less among husband and wife and family subscribers. Cancellations are, therefore, greatest among those from whom the plans ordinarily derive the largest margin of income over hospitalization expense. That the more advantageous risks tend to cancel and the least advantageous tend to retain membership is also shown by the fact that the rate of utilization among group conversion members (those originally enrolled in groups who have converted to direct payment) is often 50 to 100 percent higher than for the whole body of subscribers. The explanation of this, of course,

^{4/} J. D. Colman and H. V. Keyser, *A Study of Cancellation and Conversion Experience*, Associated Hospital Service of Baltimore, October 10, 1946.

is that those who will shortly need maternity care or who know of some condition requiring hospitalization will tend to retain their membership when making a change of employment. The tendency of cancellations to lower a plan's quality of risks would be serious if cancellations were not offset by new membership. In practice, however, they are. By constantly increasing enrollment the plans are continually refreshing their average quality of risks, in other words they are constantly enrolling or re-enrolling the better risks whom they lose through cancellations.

WAYS AND MEANS OF REDUCING CANCELLATIONS

During recent years the plans have taken greater interest in the problem of cancellations. Because the rate of cancellation among "direct payment" subscribers is high and the costs of collecting subscription charges in this manner is higher than through payroll deduction, a number of the plans have taken steps to encourage direct payment subscribers whenever possible to transfer to groups. (Some subscribers who go on direct payment after leaving an employed group, stay on this basis even though subsequently they take employment at a place with an enrolled group.) One device being resorted to more and more frequently is to impose an extra "service" charge on direct payment subscribers so as to give such subscribers an incentive to transfer to a group when they can.

In order to keep cancellations at a minimum during the reconversion period following V-J day many of the plans took special measures. First through newspaper stories, advertisements, radio announcements, posters in plants, etc., these plans broadcast the message to the public that membership could be retained when changing employment. Emphasis was placed both on the advantages of retaining membership and the means of so doing. Secondly, special efforts were made to reach employees about to be laid off. With the cooperation of management, transfer forms were distributed among such employees and enrollment representatives were stationed in the personnel offices during the mass termination period. Concerns were requested to allow extra or double deductions from the separation pay and promptly to transmit to the plans information on employee terminations and the home addresses of terminated employees.

It is probable that a good many of the plans will make continuing use of the techniques developed during the reconversion period in order to hold cancellations to a minimum. The idea is gaining currency that cancellation rates can be affected by plan policy. The main occasion for cancellations is change in employment. The extent of cancellations on these occasions depends upon education of the subscribing public as to the advantages of retaining membership and the means of so doing.

CHAPTER 12

HOSPITAL UTILIZATION EXPERIENCE

The purpose of this chapter is not to give an exhaustive study of the actuarial experience of Blue Cross plans, but to present those few basic facts concerning hospital utilization experience which are necessary for an understanding of the operation of the plans.

ADMISSION RATES, LENGTH OF STAY, DAYS UTILIZED

The early Blue Cross plans established their rates and benefits on the calculation, based on various studies, that in any one year one out of every ten participants would be hospitalized, that the average length of stay per case would be 10 days, and that the overall utilization of care would be one day per participant per year. The per diem cost of the hospital service to be provided, plus allowances for administrative expense and additions to reserves, indicated the income per participant which the plan's rates would need to yield.

In recent years the average admission rate has tended to be slightly higher than, and the average length of stay to be lower than, the rates indicated by these earlier studies. In 1946, the average annual admission rate for the plans reporting this rate to the Blue Cross Commission, was .1112 per participant (111.2 admissions per thousand participants). The average length of stay was 8.30 days. The approximate average utilization indicated by these data was .923 days per participant.

Figure 12 shows the annual admission rates and average length of stay per case by months during 1943, 1944, 1945 and 1946. It will be seen that admission rates are relatively high and average length of stay low during the summer months. This is due chiefly to the large number of tonsillectomies performed on children during these months. Admission rates in December are low because of the postponement of elective operations during the Christmas season, and the average length of stay in this and the other winter months tends to be relatively long.

As shown by Table 15, both admission rates and the average length of stay per case dipped during the war years and increased in 1945 and again in 1946.

As shown by the following data, participants under the family contract use the least amount of care per participant, and participants under the two person contract the most:^{1/}

	<u>One Person Contract</u>	<u>Two Person Contract</u>	<u>Family Contract</u>
Admissions per participant	.10	.10	.09 ^{2/}
Average Length of Stay	8.72	9.33	7.17
Patient Days per participant	.92	.97	.67

^{1/} Based on data from 31 plans for the year 1944. The figures are the medians. Data from the Blue Cross Commission.

^{2/} The median average number of participants per family contract is 3.84 (52 plans).

TABLE 15

Annual Admission Rates, Average Length of Stay
and Patient Days per Participant, 1940-1946. Medians and Averages
for All Reporting Plans.^{1/}

ADMISSIONS PER PARTICIPANT			AVERAGE LENGTH OF STAY		PATIENT DAYS PER PARTICIPANT	
YEAR	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN
1940	.105		8.1		.91	
1941	.107		7.6		.81	
1942	.108	.1080	7.8		.83	
1943	.103	.1062	7.8	7.55	.79	.802
1944		.1032		7.26		.749
1945		.1067		8.08		.862
1946		.1112		8.30		.923

^{1/} Based on data from all plans reporting for each period. Only the medians (not averages) are available for the years 1940-42. The median number of patient days per participant does not necessarily equal the product of the admissions per participant and average length of stay. The averages are the weighted averages for all reporting plans, e.g., total admissions divided by average total number of participants, etc. Monthly admissions were reported by 50 to 81 plans during 1942-45; average length of stay by 16 to 32 plans. The average number of patient days per participant is obtained by multiplying the admission rates and average length of stay for the reporting plans, and thus is an approximation. A number of the plans count hospital visits of ambulatory patients (emergency room service) as hospital admissions. The number of such visits is not known, but it is believed to be relatively small. Their inclusion tends to increase the hospital admission rate and decrease the average length of stay.

SOURCE: *Special Studies, Series No. 67* of the Blue Cross Commission; also other data from the Commission.

Similar data classified by sex are presented in Table 16. It will

TABLE 16

Admission Rates, Length of Stay and
Patient Days by Sex, and Type of Contract.^{1/}

(Median data for 15-17 Plans, 1944)

	ONE PERSON CONTRACT		TWO PERSON CONTRACT		FAMILY CONTRACT		
	ADULT MALE	ADULT FEMALE	ADULT MALE	ADULT FEMALE	ADULT MALE	ADULT FEMALE	CHILDREN
ADMISSIONS PER PARTICIPANT	.10	.10	.07	.14	.06	.15	.08
AVERAGE LENGTH OF STAY	9.23	9.08	8.96	9.60	7.71	9.03	4.56
PATIENT DAYS PER PARTICIPANT	.95	.93	.71	1.28	.51	1.31	.40

^{1/} Data from the Blue Cross Commission.

be seen that single adult males and females use approximately the same amount of care. Married females use more than twice as much care as married adult

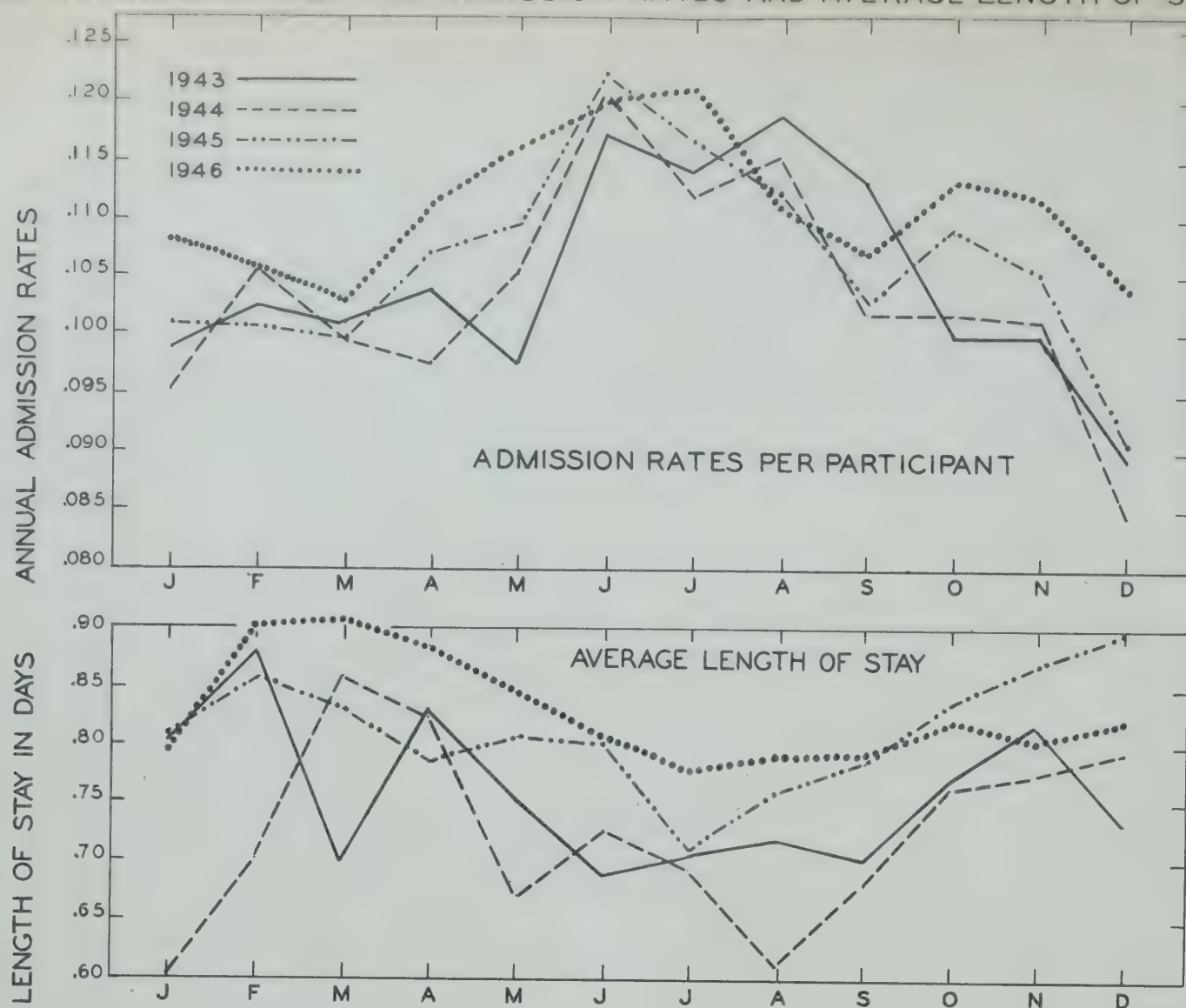


FIGURE 12

males. Children use the least amount of care per person. They are admitted to hospitals at almost the same frequency as single subscribers, but their average stay is less than half that of adults, due in good part to short stay tonsil and adenoid cases.

As may be surmised there is considerable variation among the plans in their hospital utilization rates. In 1943, for example, utilization ranged from .47 patient days per participant in one plan to 1.17 days per participant at the other extreme. The distribution of 55 reporting plans according to patient days per participant in this year was as follows:^{3/}

Range Patient days per Participant	Number of Plans
.40 - .49	1
.50 - .59	2
.60 - .69	6
.70 - .79	21
.80 - .89	11
.90 - .99	9
1.00 - 1.09	4
1.10 - 1.19	1
Total	55

^{3/} Data from the Blue Cross Commission.

These differences may, in part, reflect possible differences in illness rates among the general populations of the different areas. To a much greater degree they reflect differences among the enrolled populations in age and sex composition, marital status, customs in the utilization of hospitals, health consciousness, length of membership (which effects eligibility for maternity care), etc. They also reflect differences among the plans in the extent to which the enrolled participants constitute an average selection of risks, in the scope and duration of benefits (comprehensive scope of benefits encourages utilization), in the conditions covered, in the degree of cooperation secured from participating hospitals, in the extent to which crowding of hospitals in the various areas may have acted to curtail admissions and shorten stays, etc. Differences among the plans in the inclusion of out patient cases as hospital admissions are also a factor.

UTILIZATION BY METHOD OF ENROLLMENT AND PAYMENT

The following figures show the median patient days per participant, according to type of participant, as reported by 11 plans for the year 1943:^{4/}

Type of Participant	Median Patient days per participant
Group Remittance	.759
Group Direct	1.034
Group Conversion	1.158
Miscellaneous ^{5/}	.917
All	.794

It is evident that group remittance participants, i. e., those who pay through organized groups, have the lowest utilization rates and hence constitute the better risks. Group direct participants, i. e., those enrolled on a group basis, but who pay the plan direct (members of medical, dental, nursing and legal associations tend to comprise the great majority of this class), are relatively poor risks. This is probably due not so much to the methods of enrollment and payment, as to the fact that these participants because of their occupations and cultural status, are extremely health and hospital conscious. Group conversion participants, i. e., those who have left organized groups and now pay the plan direct, have the highest utilization rates. This group tends to become adversely selected since (a) persons leaving employment because of sickness or maternity tend to continue their membership by going on a direct payment basis, (b) among persons leaving employed groups, those who anticipate needing hospital care in the near future keep up their membership in far greater proportion than those who have no such anticipation.

^{4/} Data from the Blue Cross Commission.

^{5/} Miscellaneous participants comprise sponsored dependents and any other participants not included in the other categories.

UTILIZATION UNDER WARD AND SEMI-PRIVATE CONTRACTS

The following data, based on reports from ten plans for the year 1943, shows that utilization is appreciably less under ward than under semi-private contracts:^{6/}

	<u>Ward Contracts</u>	<u>Semi-Private Contracts</u>
Median Admissions per contract	.198	.214
Median Admissions per participant	.077	.100
Median Average Length of Stay	7.31	7.94
Median Patient Days per participant	.564	.784

In part the lesser utilization per participant is due to the greater presence of children, with their low rate of utilization, among ward than semi-private subscribers. But in large part, the difference is probably due to differences between the two groups of subscribers, in health consciousness, in ability to afford physicians' services and in proneness to seek hospital care.

OTHER FACTORS INFLUENCING UTILIZATION

The experience of the plans appears to justify the following observations.

Residents of cities use more hospital care than residents of rural areas. This is probably due largely to city dwellers being more accustomed to using hospitals and being nearer to them.

Professional groups use more care than other occupational groups. Utilization is particularly high among physicians, nurses and hospital employees. (Utilization is so high among hospital employees, that most plans enroll such employees only with the proviso that the plan will not pay out in benefits more than a certain proportion of the income received from these subscriptions, the hospital being responsible for any excess.)

Plans providing a comprehensive scope of hospital service tend to have higher utilization rates than those which provide limited benefits.

Plans with full coverage of dependents experience higher utilization rates among dependents than plans with partial coverage of dependents.

Utilization among persons 65 and over is about double that for all ages.^{7/}

^{6/} Data from the Blue Cross Commission.

^{7/} For example, data from the Baltimore plan for the year 1945 show the following rates:

<u>Age</u>	<u>Patient Days to Dis- charge per Person-Month*</u>
0-4	.0356
5-19	.0426
20-29	.0674
30-39	.0716
40-64	.0785
65 plus	.1334
Average	.0643

*Out-Patient Visits counted as one day.

DISTRIBUTION OF CASES BY LENGTH OF STAY

The following data (Table 17) from the New York City plan, illustrates the general pattern of the distribution of hospital cases according to length of stay.

It will be seen from this experience that a plan which provided 21 days of care for each illness would provide full coverage of about 92 percent of all non-maternity cases and of 69 percent of all days of hospitalization for such illnesses. If 30 days of care were provided, 96 percent of all cases and 79 percent of all days of hospitalization would be covered in full. The inclusion of maternity cases, which, in the New York experience, comprised almost 24 percent of all hospital cases, would serve to bring up the degree of coverage. Most plans place a limit of 10 days on maternity stays and this length of stay probably suffices for most uncomplicated maternity cases. Based on this experience it may be roughly calculated that a plan which provided 21 days of care in each illness would provide full coverage for about 94 percent of all (both non-maternity and maternity) general hospital cases and about 76 percent of all days of care. If the plan provided 30 days of care for each illness, about 97 percent of all cases and 84 percent of all days would be covered in full.

It is obvious that an increase in the days of coverage afforded by a plan does not involve a corresponding increase in the plan's hospitalization expense. For example, an increase in days of care provided from 21 per illness to 30 per illness would increase the days of care for which the plan would have to be responsible by about 10 percent.^{8/} An increase in the number of days provided from 30 to 45 would increase the total days of care for which the plan would be responsible by about 8 percent. The increase in hospitalization expense would be considerably less than these figures indicate inasmuch as the hospital expenses for these days would include very little expense for the special services. However, a plan in increasing the days of coverage provided must take into account the possibility that the extension of coverage may in itself tend to alter hospital usage, i. e., increase the stay of long stay cases. Column two of Table 17 shows a sharp drop in the number of cases staying 22 days as compared with those staying 20 and 21 days, indicating a certain tendency of cases presumably requiring prolonged care to stay up to the limit of the coverage provided and to terminate their stay when coverage is no longer available.

HOSPITAL UTILIZATION OF BLUE CROSS SUBSCRIBERS COMPARED WITH THAT OF THE POPULATION AS A WHOLE.

The hospital admission rate among Blue Cross subscribers (106.7 per 1,000 in 1945) is higher than the rate (96.8 per 1,000) at which the civilian population of the country as a whole in 1945 was admitted to general ^{9/} hospitals.^{10/} The average stay of Blue Cross patients (8.1 days per case) is

^{8/} For both maternity and non-maternity cases.

^{9/} i. e., all hospitals other than mental and tuberculosis hospitals.

^{10/} Calculated from data in *Hospital Service in the United States*, 1946; *Journal of the American Medical Ass'n.*, April 20, 1946. Civilian admissions and patient days were calculated by subtracting from total admissions and total census; the admissions and census in all mental and tuberculosis hospitals and in all general, special and institutional hospitals operated by the Federal government, and then by adding the admissions and census in Federal general hospitals in peace time (1938).

TABLE 17

Distribution of Non-maternity Cases by Length of Stay
(Associated Hospital Service of New York -- 90,753
Claims Incurred in 1942 and Paid to April 1, 1943.)

LENGTH OF STAY	NUMBER OF CASES	NUMBER OF DAYS	PERCENT OF CASES	PERCENT OF DAYS	CUMULATIVE PERCENT OF CASES	CUMULATIVE PERCENT OF DAYS
1	17,049	17,049	18.79	1.90	18.79	1.90
2	7,688	15,376	8.47	1.72	27.26	3.62
3	4,994	14,982	5.50	1.67	32.76	5.29
4	4,854	19,416	5.35	2.17	38.11	7.46
5	4,577	22,885	5.04	2.56	43.15	10.02
6	4,225	25,350	4.66	2.83	47.81	12.85
7	4,056	28,392	4.47	3.17	52.28	16.02
8	3,607	28,856	3.97	3.23	56.25	19.25
9	3,427	30,843	3.78	3.45	60.03	22.70
10	3,851	38,510	4.24	4.30	64.27	27.00
11	3,601	39,611	3.97	4.42	68.24	31.42
12	3,059	36,708	3.37	4.10	71.61	35.52
13	2,941	38,233	3.24	4.27	74.85	39.79
14	3,274	45,836	3.61	5.12	78.46	44.91
15	2,589	38,835	2.85	4.34	81.31	49.25
16	2,149	34,384	2.37	3.84	83.68	53.09
17	1,783	30,311	1.96	3.39	85.64	56.48
18	1,501	27,018	1.66	3.02	87.30	59.50
19	1,276	24,244	1.40	2.71	88.70	62.21
20	1,354	27,080	1.50	3.02	90.20	65.23
21	1,440	30,240	1.58	3.38	91.78	68.61
22	681	14,982	0.75	1.67	92.53	70.28
23	562	12,926	0.62	1.45	93.15	71.73
24	467	11,208	0.52	1.25	93.67	72.98
25	450	11,250	0.49	1.26	94.16	74.24
26	371	9,646	0.41	1.08	94.57	75.32
27	344	9,288	0.38	1.03	94.95	76.35
28	402	11,256	0.44	1.26	95.39	77.61
29	259	7,511	0.29	0.84	95.68	78.45
30	238	7,140	0.26	0.80	95.94	79.25
31	232	7,192	0.26	0.80	96.20	80.05
32-45	1,868	69,858	2.05	7.80	98.25	87.85
46-60	804	41,793	0.89	4.67	99.14	92.52
61-70	271	17,632	0.30	1.97	99.44	94.49
71-81	148	11,177	0.16	1.25	99.60	95.74
82-90	90	7,743	0.10	0.87	99.70	96.61
91-111	219	22,895	0.24	2.56	99.94	99.17
OVER 111	50	7,467	0.06	0.83	100.00	100.00
TOTAL	90,753	895,123	100.00	100.00	100.00	100.00

markedly shorter than the average stay (12.4 days) of general hospital patients among the whole civilian population. The patient days per participant (.86 in 1945) reported by the Blue Cross plans is less than the average per capita number of days of care in general hospitals (1.20 days) received by the whole civilian population in 1945.

The higher admission rate among Blue Cross subscribers than among the general population may perhaps be due primarily to a tendency of insured persons, owing to removal of the financial barrier, to seek hospital care earlier in illness and in less severe conditions than non-insured persons. A factor is that the admissions reported by some plans include out-patient admissions. The same factors, and those indicated below may explain the shorter average stay of Blue Cross subscribers.

The lower overall utilization rate (which largely eliminates the factor of out-patient admissions) among Blue Cross subscribers than among the general population may be due primarily to differences in the composition of the two population groups and to the fact that the plans do not cover all types of cases. Blue Cross subscribers do not constitute a cross section of the population; they consist almost entirely of actively employed persons and their dependent spouses and children -- the aged, the invalid and the chronically ill do not have the opportunity of becoming members. At any one time close to one-fifth of Blue Cross subscribers are not eligible for maternity care. The plans do not cover workmen's compensation cases and cases hospitalized in veterans' hospitals.

DIAGNOSIS AND UTILIZATION

Table 18, giving data from the New York City plan, shows the distribution of cases and patient days of care according to diagnosis. Maternity cases constitute the most important single group both from the standpoint of admissions and days. Tonsillectomies constitute a large proportion (11.7%) of all cases, but because of the short stay, are relatively unimportant from a standpoint of days of care. Appendicitis cases constitute 5.7 percent of all cases and are responsible for 6.5 percent of all days of care.

Table 19 shows those diagnoses which accounted for more than one percent of the total hospitalization cost to the New Jersey plan in 1943.

COMPOSITION OF THE HOSPITAL BILL

A plan, in determining what hospital service benefits to provide and what rates to charge, must know the frequency with which the various special hospital services are provided to patients and the average charges for these services per case and per day of care. Table 20 presents the necessary data for an over-all picture of the situation. These data are from an inter-plan study of representative hospital bills for semi-private, non-maternity care.

It will be seen that charges for room and board constitute about two-thirds of the total charges for semi-private hospital care. Charges for use of the operating room constitute 10.7 percent of average charges, those for laboratory service, 8.6 percent, and charges for x-ray service, 6.3 percent of the total. Charges for anesthesia constitute 3.3 percent of total charges and those for drugs 3.7 percent. None of the other hospital services involve charges of more than one percent of total charges, on the average.

TABLE 18

Distribution of Cases and Days of Care
According to Diagnosis
(Associated Hospital Service of New York
Summary of 121,053 claims paid in 1943.)

DISEASE CLASSIFICATION	NUMBER OF CASES	AVERAGE DAYS' STAY	PERCENT OF TOTAL CASES	PERCENT OF TOTAL DAYS
MATERNITY				
DELIVERY	25,289	10.5	20.89	21.88
OTHERS	3,477	6.4	2.87	1.83
INFECTIOUS & PARASITIC	851	17.2	0.70	1.21
MALIGNANT TUMORS	2,463	21.9	2.03	4.45
BENIGN TUMORS				
FEMALE GENITAL ORGANS	4,881	14.0	4.03	5.63
FEMALE BREAST	1,086	5.5	.90	0.49
OTHERS	2,877	7.5	2.38	1.78
RHEUMATIC & NUTRITIONAL	2,351	15.1	1.94	2.93
BLOOD & BLOOD FORM. ORG.	648	11.5	0.54	0.61
CHRONIC POISON & INTOX.	67	6.2	0.06	0.04
NERV. SYS. & SENSE ORG.	4,176	12.0	3.45	4.13
CIRCULATORY SYSTEM				
HEMORRHOIDS	1,948	7.8	1.61	1.25
OTHERS	4,925	15.7	4.07	6.37
RESPIRATORY SYSTEM				
TONSILLECTOMY	14,227	1.3	11.75	1.52
INFLUENZA, BRONCHITIS, AND PNEUMONIA	6,929	11.3	5.72	6.45
OTHERS	5,952	7.6	4.92	3.73
DIGESTIVE SYSTEM				
APPENDICITIS	6,855	11.5	5.66	6.50
HERNIA	2,069	15.3	1.71	2.61
GALLBLADDER & DUCT.	2,122	15.8	1.75	2.76
OTHERS	6,694	11.3	5.53	6.23
GENITO-URINARY SYSTEM	8,096	10.1	6.69	6.74
SKIN DISEASES	2,133	8.5	1.76	1.49
BONES & ORG. OF MOVE.	2,488	15.1	2.06	3.10
INJURIES & POISONINGS	7,235	8.6	5.98	5.13
MISCELLANEOUS	1,214	11.4	1.00	1.14
TOTAL	121,053	10.0	100.00	100.00

TABLE 19 Distribution of Cases, Days of Care and Hospitalization Expense According to Diagnosis. Data from New Jersey Plan, 1943.			
DIAGNOSIS	PERCENT OF TOTAL CASES	PERCENT OF TOTAL DAYS' CARE	PERCENT OF TOTAL EXPENSES
MATERNITY	22.97	25.29	28.19
TONSILS & ADENOIDS	16.69	2.73	4.48
APPENDICITIS	9.97	11.95	12.03
FEMALE DISEASES	9.74	10.62	10.84
ACCIDENTS	6.74	5.65	4.92
CHEST COLDS	4.97	5.64	5.32
TUMORS	2.71	2.51	2.46
RECTAL	2.54	2.24	2.35
HERNIA	1.98	3.39	3.26
GALL BLADDER	1.89	2.99	2.85
INTESTINAL DISORDERS	1.81	2.01	1.87
INFECTIONS	1.77	1.57	1.50
KIDNEY	1.77	1.95	1.87
HEART	1.42	2.95	2.35
ULCER	1.33	2.09	1.92
BLOOD DISEASES	1.21	1.87	1.56
CANCER	1.05	2.44	1.89
GLAND	0.93	1.32	1.24
ALL OTHER	8.51	10.79	9.10
TOTAL	100.00	100.00	100.00

TABLE 20 AVERAGE HOSPITAL CHARGES Based on 6,420 representative hospital cases of 29 plans, 1942. Semi-private, non-maternity cases only. ^{1/}					
SERVICE	AVERAGE CHARGES PER DAY	AVERAGE CHARGES PER CASE	PERCENT OF CHARGES	PERCENT OF CASES CHARGED FOR SERVICE	AVERAGE CHARGE WHEN CHARGED FOR SERVICE
ROOM AND BOARD	\$4.71	\$38.55	64.7%	100.0%	\$38.56
OPERATING ROOM	.78	6.37	10.7	62.8	10.14
ANESTHESIA	.24	1.99	3.3	28.6	6.97
LABORATORY	.62	5.10	8.6	85.5	5.97
X-RAY	.46	3.74	6.3	23.4	15.97
DRUGS	.27	2.23	3.7	49.4	4.50
DRESSINGS	.06	.51	0.9	16.1	3.16
ELECTRO-CARDIOGRAM	.02	.12	0.2	1.4	8.54
BASAL METABOLISM	.02	.12	0.2	1.8	6.76
PHYSIO-THERAPY	.03	.23	0.4	1.7	12.98
OXYGEN THERAPY	.02	.19	0.3	1.4	13.52
RADIUM THERAPY	.01	.05	0.1	0.2	30.40
OTHER SERVICES	.04	.40	0.6	3.7	9.97
	\$7.28	\$59.60	100.0%		

^{1/} Thompson, Allen B. *Inter-Plan Study of Semi-Private Non-Maternity Hospital Bills.*
Associated Hospital Service of New York, 1944.

CHAPTER 13

THE NATIONAL COORDINATION OF THE PLANS

Blue Cross plans are coordinated through a central organization, an approval program and various other measures.

The central authority of the plans is the conference of representatives of the plans. Such conferences are usually held twice a year, each plan being represented by a duly accredited delegate, usually the executive director. In voting at such conferences, each plan has one vote for each 20,000 subscriber contracts or fraction thereof, with a minimum of one vote and a maximum of ten votes per plan. In certain respects the actions of the conference of plans may be over-ruled or superseded by action of the Board of Trustees of the American Hospital Association or its House of Delegates, and in the last analysis the latter organization may perhaps be considered the final repository of authority for the plans.

All approved plans have the privilege of becoming institutional members of the American Hospital Association and the latter has created a special type of membership (Type IV) for which the plans are eligible. All of the approved plans except one have exercised the privilege of this membership. The exception is the District of Columbia plan which has refused to accept membership on the grounds that the plans should not be affiliated with the American Hospital Association.

The coordinating agency of the plans is the Blue Cross Commission of the American Hospital Association. Up until December 1946 this Commission was composed of nine persons, selected for overlapping three year terms, three of whom were selected by the American Hospital Association and six of whom were elected by weighted vote of the plans. At a meeting in December 1946 the plans voted to reorganize the Commission so as to make it more representative of and bring it closer to the plans. Under the proposed reorganization, which does not become formally effective until ratified by the House of Delegates of the American Hospital Association, the Commission will consist of 15 persons, 3 selected by the Association and 12 by the plans. The plans will be grouped into 12 districts, 11 in the United States and one in Canada, and each district will elect its representative to the Commission on the basis of one vote per plan.

The Commission meets several times a year and determines matters of broad policy. Its executive activities are carried on by a permanent staff with headquarters at the office of the American Hospital Association. The funds of the Commission are obtained by dues paid by the plans, in the amount of two mills monthly per subscriber contract, with a minimum payment of \$32 and a maximum of \$800 a month. The Commission's budget for 1946 was \$134,000.

The Commission in cooperation with the Board of Trustees of the American Hospital Association carries on the approval program. In addition it serves as a clearing house of information, carries on research and statistical studies, consults with individual plans on administrative and other problems, carries on a broad educational or publicity program to interpret the Blue Cross movement to the general public and its various component groups, maintains the national enrollment office, provides advice and guidance to groups interested in the establishment of new plans, acts as spokesman for the plans before government bodies and industrial, labor, farm and other groups, arranges conferences of the plans, and develops procedures for coordination of the services and activities of the individual plans.

THE APPROVAL PROGRAM

The approval program was initiated in 1938 with the primary purpose of enabling the public to differentiate between the non-profit hospital-sponsored plans and insurance companies. It soon became evident that the public was attaching to approval an implication that the American Hospital Association guaranteed the financial responsibility of the several plans. To meet this implication the approval program laid stress on the financial status of the plans. In recent years, in addition to designating for the public plans which were non-profit, financially sound and backed by the hospitals, an attempt has been made to use the program as a means of strengthening the movement as a whole and increasing its growth.

The final responsibility for the approval program rests with the Board of Trustees of the American Hospital Association. The Board establishes the standards and may from time to time amend them. It may in its discretion waive or vary specific requirements in the consideration of individual applications for approval.^{1/}

Approval of a plan entitles it to the privilege of membership in the American Hospital Association, enables the plan to utilize the Blue Cross symbol (the seal of the Association superimposed upon a Blue Cross) and to call itself a Blue Cross plan. Plans are approved or reapproved each year. Each year a certain date is designated as "Approval Day" at which time announcement of approval and reapproval of plans is made.

A great deal of responsibility in connection with the approval program is carried by the Commission. The plans are required to submit to the Commission financial, enrollment and other data needed for appraisal. The Commission considers carefully all applications for approval or reapproval and submits to the Board of Trustees its recommendations for action to be taken, together with data required for the appraisal of plans. The Commission and the Trustees together will hear any complaints or data to be presented in connection with approval or reapproval of individual plans.

THE STANDARDS OF APPROVAL

The standards of approval were revised in September 1946. They are in two parts, a statement of "Principles" which serves as a basis for considera-

^{1/} The by-laws of the American Hospital Association state that "The Board of Trustees shall establish standards for and administer a program of annual approval for organizations operating non-profit hospital service plans which apply for such approval. The purpose of the standards shall be to protect the interests of the subscribers, the medical profession and the hospitals."

tion of plans for initial approval, and standards for annual re-approval. They are as follows:

1. PRINCIPLES OF ORGANIZATION AND OPERATION FOR BLUE CROSS PLANS

These principles are the basis for consideration of applications from non-profit hospital service plans for original approval by the American Hospital Association. Approval makes such plans eligible for membership in the Association and authorizes their use of the seal of the Association, superimposed upon a Blue Cross, as the identifying symbol of a hospital service plan's organization and operation.

1. Adequate representation of hospitals, the medical profession and the general public. The interests and the responsibilities of participating hospitals make it desirable that a majority of the policy-making body be hospital trustees, administrators, and/or authorized representatives of the member hospitals.

2. Non-profit sponsorship and control. Trustees or board members of the hospital service plan should receive no remuneration for service as trustees or board members.

Initial working capital may be provided by individuals, hospitals, chests, councils, or other civic agencies, but should be repayable only out of earned income, over and above operating expenses, payments to participating hospitals, and legal reserve.

No organizations or individuals advancing initial capital should attempt to influence or direct the management of Blue Cross Plans because of their financial support.

3. Free choice of hospital and physician. Opportunity should be given for all institutions of standing in each enrollment area to become member hospitals in the Blue Cross Plan, and subscribers should have free choice of hospital at the time of sickness, such choice to be consistent with the staff privileges of the subscribers' attending physicians.

A majority of the hospitals of standing, containing a majority of the bed capacity, should be member hospitals in each area where a Blue Cross Plan enrolls subscribers, and arrangements should be made for provision of service in non-member hospitals.

In case of physical impossibility to provide service in member hospitals or others, equitable arrangements should be made for protection of the subscribers' interests, but which would not threaten the Plan's stability and continuity in the event of epidemic or disaster.

Blue Cross Plans should not interfere with existing relationships between physicians and hospitals or between physicians and patients.

4. Responsibility for benefits to subscribers. The ultimate economic responsibility for benefits to subscribers enrolled at any given time must be assumed by the member hospitals, through definite contractual agreements with the Blue Cross Plan, which express such intent by the hospitals. In the absence of a provision in the hospital contract which establishes hospital-responsibility for contract-benefits, each Plan shall proceed to establish contingency reserves (over and above all liabilities) equal to at least 5 percent of its previous annual income, beginning with the calendar year 1947, until such contingency reserves shall equal 25 percent of the Plan's current annual income.

Hospital service provided through a Blue Cross Plan should be determined by the practices of the member hospitals of the particular plan. Member hospitals

are urged to cooperate with Blue Cross Plans in providing complete hospital care as service benefits under the subscribers' contracts.

5. Enrollment areas and practices. Plans should be established only where needs of a state or province are not adequately served by existing Blue Cross Plans.

Adequate spread of risk, efficient management, and effective co-ordination require that each Plan serve the largest possible geographic area that legal restrictions and economic conditions permit.

A hospital service plan located in or near an area already adequately served by an approved plan will not necessarily be approved by the Board of Trustees, even though such plan may enjoy sound financial position and reputable local sponsorship. Plans applying for approval will be expected to "show cause" why they should not merge their activities with approved Blue Cross Plans which are in a position to serve the trading area economically and effectively. The trading area for each Blue Cross Plan should have a population of at least 500,000 persons.

Enrollment practices shall be such as can reasonably be expected to assure a utilization approximating that of the general population and such as will not expose the plan to adverse selection. The group enrollment principle is the only method that has completely proven its ability to accomplish this result. Experimentation in other enrollment methods is encouraged but with such controls as may be expected to safeguard the interest of subscribers and member hospitals.

Where community response has been slow, as measured by enrollment, the Blue Cross Plans should review and, if necessary, revise their rates, benefits, administration, enrollment methods, or public policies; also, consider the possibility of expanding their service by increasing the territory to be served or by merger with other Blue Cross Plans which might serve their respective areas more effectively.

6. Sound accounting practices. The Hospital Service Plan Commission shall enforce minimum standards of sound accounting practices not inconsistent with the requirements of state regulatory bodies. The Hospital Service Plan Commission shall also require each approved plan to submit reports (at least semi-annually) of financial experience in such form as may be prescribed by the Hospital Service Plan Commission.

Before certifying to the Board of Trustees of the American Hospital Association that the plan has conformed to its minimum standards of sound accounting practices, the Hospital Service Plan Commission shall satisfy itself that the plan's balance sheet contains an accurate statement of its liabilities, including allowances for accounts and notes payable and unearned subscription income, as well as adequate reserves for unreported and undischarged hospital cases.

7. Adequate general or contingency reserves. Initial working capital should be sufficient to carry all acquisition costs and operating expenses for at least four months after contracts first become effective.

The Hospital Service Plan Commission shall expect each plan to establish, over and above all liabilities, a reserve for contingencies to cover such items as fluctuations in morbidity, major epidemics, future maternity claims, fluctuations in asset values, etc.

It is recognized that the rate at which a plan establishes a reserve adequate for these purposes will depend upon many factors, such as rate of membership growth, administrative policy, age of the Plan, type of benefits offered, rate structure, etc. The interests of subscribers and member hospitals

make it imperative that administrative expenses of Blue Cross Plans be as low as consistent with effective public service.

8. Adequate statistical records. As a minimum statistical record of its operation each approved plan should currently assemble and report the following data (preferably quarterly):

The number of contracts, participants and participants eligible for maternity service, as of the end of the period; the number of patients, patient days, maternity patients, and cost of hospital care during the period, classified as to type of contract and method of enrollment.

Compilation of additional data by individual plans on their specific problems is essential to an understanding of their operation. Each plan is expected to undertake statistical studies in addition to the minima outlined above.

9. Equitable payments to hospitals. In the development of any method of payment by Blue Cross Plans for contract benefits in member-hospitals, the representatives of hospitals and Blue Cross Plans should insist upon having adequate financial and service data concerning the operation of hospitals and Blue Cross Plans.

Officially appointed representatives of the Blue Cross Plans should meet with officially appointed hospital representatives in any given area for a free and frank expression of opinion on the rates to be paid to hospitals, and the principles and the formula on which such rates would be established. Any conclusion reached by the representatives of the two organizations, plans and hospitals, should not become effective until approved by at least 50 percent of the member hospitals representing at least three-fourths of the patient days of service rendered Blue Cross subscribers during the past 12 months. Any rate approved should be reviewed at least once a year for such adjustments as might be necessary to protect the interests of subscribers, hospitals and plans.

10. Dignified promotion and administration. Employees of a Blue Cross Plan should be reimbursed by salary as opposed to a commission basis. A private sales organization must not be given responsibility for promotion or administration on the basis of a percentage of premiums. Promotion and administrative policies should be dignified in nature, consistent with the professional ideals of the hospitals concerned.

11. Inter-plan coordination. Individual Blue Cross Plans should coordinate their activities through uniform and equitable policies and procedures which will maximize their service to the entire population throughout the United States and Canada. This applies to (a) convenient transfer of members who change their permanent residence, (b) reciprocal service benefits for subscribers hospitalized outside the enrollment area of their "home" plan, (c) uniform enrollment and billing procedures for employees of national firms enrolled through two or more plans, (d) consolidated billing for employees of national firms which request such procedure.

There should be a clear-cut understanding as to the plan with which a member-hospital signs a guarantee contract. Under ordinary circumstances, the hospitals should sign contracts with only one plan.

Where legally permissible, hospitals are urged to provide service benefits to subscribers of other Blue Cross Plans on some basis agreeable to both Plans. Where it is illegal or impractical for a Blue Cross Plan to arrange service benefits in the member hospitals of other plans, each Blue Cross Plan is urged to adjust out-of-town allowances to amounts which provide the maximum contract benefits consistent with sound financial operation.

II. STANDARD OF ANNUAL REAPPROVAL OF BLUE CROSS HOSPITAL SERVICE PLANS

1. THERE WILL BE representation of hospitals, the medical profession, and the general public upon the governing boards.

2. Non-profit sponsorship and control shall be required. Trustees or board members of the hospital service plan should receive no remuneration for services as trustees or board members.

Initial working capital may be provided by individuals, hospitals, chests, councils, or other civic agencies, but should be repayable only out of earned income, over and above operating expenses, payments to participating hospitals, and legal reserve.

No organizations or individuals advancing initial capital should attempt to influence or direct the management of Blue Cross Plans because of their financial support.

3. Free choice of hospital and physician shall be required. Opportunity should be given for all institutions of standing in each enrollment area to become member-hospitals in the Blue Cross Plan serving the area. Subscribers should have free choice of member-hospital consistent with the privileges of their attending physicians, and be entitled to stated benefits in other hospitals when service in member-hospitals cannot be obtained.

4. Hospitals shall be responsible for benefits to subscribers. The ultimate economic responsibility for service to subscribers enrolled at any given time must be assumed by the member hospitals, through definite contractual agreements with the Blue Cross Plan, which express such intent by the member hospitals.

In the absence of a provision in the hospital-contract which establishes hospital responsibility for contract benefits, each Plan shall proceed to establish contingency reserves (over and above all liabilities) equal to at least 5 percent of its previous annual income beginning with the calendar year 1947, until such contingency reserves shall equal 25 percent of the Plan's current annual income.

5. Sound accounting practices and adequate statistical records shall be maintained. The Blue Cross Commission shall prescribe minimum standards of sound accounting practices not inconsistent with the requirement of state regulatory bodies. The Blue Cross Commission should also require each approved plan to submit periodic reports of financial experience (at least semi-annually) in such form as may be prescribed by the Blue Cross Commission.

Before certifying to the Board of Trustees of the American Hospital Association that the plan has conformed to its minimum standards of sound accounting practices, the Blue Cross Commission shall satisfy itself that the plan's balance sheet contains an accurate statement of its liabilities, including allowances for accounts and notes payable and unearned subscription income, as well as adequate reserves for unreported and undischarged hospital cases.

6. There shall be no interference with professional relationships. Blue Cross Plans should not interfere with existing relationships between physicians and hospitals or between physicians and patients.

7. All approved Blue Cross Plans shall make every effort to comply in full with the Principles Governing the Organization and Operation of Blue Cross Plans, as established by the American Hospital Association.

OPERATION AND PROBLEMS OF THE APPROVAL PROGRAM

The operation of the approval program may perhaps best be understood through consideration of specific issues which have arisen. The differences between the standards for original approval and for reapproval and between the present standards and the former ones (prior to September 1946) also serve to indicate problems with which the movement is grappling and some of the present tendencies or trends.

CONTROL OF THE PLANS. The present standard for original approval states that majority representation of the hospitals on plan boards is desirable. The standard for reapproval requires merely that there should be representation of hospitals, the medical profession, and the public. The former (pre-1946) standards required majority representation of hospitals.

The analysis of the composition of the boards of the surveyed plans in 1944-5 indicated that in almost half of the cases hospital representatives were not in a majority. Hence it is obvious that the former standard was not being enforced; indeed because of differences of opinion as to the wisdom of the standard no consistent effort to enforce it was made. The change to the present standard recognizes overt facts and indicates that the movement has, in a sense, burst out of the former pattern of ideas wherein it was taken for granted that dominant control of the plans should lie with the hospitals.

HOSPITAL GUARANTEE OF BENEFITS - FINANCIAL SOUNDNESS. The old standard No. 4 required unequivocally that hospitals guarantee subscriber benefits. The new standards stress the idea of hospital guarantee of benefits but do not require it.

It will be recalled that the analysis of the hospital contracts indicated that in almost a third of the plans subscriber benefits are not contractually guaranteed by the hospitals. The Commission used its influence to see to it that the contracts between plans and hospitals contained a clear-cut underwriting obligation. Where the hospitals of the area would not undertake to underwrite the plan, the Commission and the American Hospital Association felt that little would be gained by endeavoring to force the issue. The change in the standards recognizes overt facts and gives sanction to arrangements under which hospitals assume less responsibility toward the plans, and hence have less claim to control.

The matter of financial soundness is closely tied up with hospital guarantee of benefits. The Commission in administering the approval program has always placed considerable emphasis upon financial soundness. Thus the only two occasions on which approval was withdrawn from a plan were because the Commission deemed that the plan had become financially unsound.^{2/} Within the last few years the Commission has been concerned over the small contingency reserves held by some plans. This concern of the Commission has been shared by various of the individual plans which have recognized that the failure of any plan would weaken the prestige of the whole movement. Indeed on at least one occasion certain of the plans have threatened to withdraw from the movement and to cease use of the Blue Cross symbol unless the Commission took steps to improve the financial situation of certain plans. In May 1945 the Commission recommended to the Board of Trustees that "no plan be approved unless it comply fully with (former) standard No. 7 (requiring adequate con-

^{2/} The Chapel Hill, N. C. plan was disapproved in 1939 and reapproved in 1940; the Easton, Pa., plan (which later became the Allentown plan) was disapproved in 1939 and reapproved in 1942.

tingency reserves) by January 1, 1947 or 3 years after first approval, whichever is later."

Although an endeavor was made to persuade certain plans which were thought to be skating on thin ice to build up larger reserves, the Commission and the Board of Trustees in recent years have not withdrawn approval from any plan on these grounds. Difficulties in enforcement of the standards may have been due in part to differences of opinion as to what constitutes adequate contingency reserves in a situation in which hospitals firmly guarantee subscriber benefits. To this extent the revised standards represent a step forward in that they lay down definite requirements for contingency reserves for plans not underwritten by their member hospitals.

From some aspects disapproval of a plan if it should get into an unsound financial position is not the best method of correcting the situation or protecting the public's interests. The withdrawal of approval at such a time conceivably might cause appreciable numbers of the plan's subscribers to desert it, the plan thus being placed in worse straits than before. Since October 1945 the plans have been giving consideration to the idea of establishing a national pool of reserves -- an inter-plan guaranty fund. The general idea is that each plan would put into such a fund a certain fraction of its current gross income, and that the Commission could then draw upon this fund to aid any plan in difficulty. Implicit in this arrangement would be the need for establishing and enforcing definite standards as to the reserves to be maintained by the individual plans, the power of the national organization to audit the funds of the plans, and assumption by the national organization of temporary control of any plan aided by the fund. In other words it would be necessary for each plan when entering into this arrangement to agree that if it did get into difficulty and asked aid from the guaranty fund the national organization would assume control of its affairs, even to the extent of replacing the management, until such time as the plan was again upon its feet and no longer in debt to the national fund.

The implications of any such arrangement are large, and many of the plans are reluctant to delegate to the national organization such authority or potential authority as would be necessary for its working. Any such guarantee fund would have an important impact upon the idea of hospital guarantee of benefits. To the extent that such a fund replaced the hospitals as the source of the ultimate guarantee of subscriber benefits, it would affect the whole character of the movement.

SERVICE BENEFITS. The former (pre-1946) standards required that "Benefits in member hospitals should be expressed in "service contracts" which describe specifically the ... services to which the subscribers are entitled." Within the last few years a growing number of the plans have offered contracts providing a dollar room allowance rather than care in specified room accommodations. At the March 1946 conference the plans deplored this tendency and resolved to recommend to the American Hospital Association that in the future plans be disapproved the member hospitals of which do not provide benefits on a "service basis."

However the pressure of circumstances in this period of rising hospital costs -- the difficulties of reaching agreement on a basis of fair remuneration, the need of the plans to stabilize their per diem hospital costs -- have been too much for the plans and the hospitals. At present writing (March 1947) the number of plans providing dollar room allowances is greater than ever before.

The differences of opinion among hospital and plan personnel as to the wisdom and feasibility of complete service benefits are recognized in the new standards. The first part of the standards contains the statement, "Member hospitals are urged to cooperate with Blue Cross plans in providing complete hospital care as service benefits under the subscribers' contracts." The standards for reapproval do not mention the subject.

AREAS SERVED BY PLANS. The standards for original approval make it clear that Blue Cross plans are intended to serve exclusive areas, that no area should be served by more than one plan. Prior to 1946 the standards which indicated this intent were a requirement for all plans.

In North Carolina there are two competing plans, one of which is endorsed by the State Hospital and medical associations. The competition of the two plans weakens the support of the hospitals, the medical profession, and the public and greatly increases administrative and acquisition costs.

In Illinois the territories of certain of the plans have not been clearly defined and one plan has conducted enrollment in areas considered by other plans to be part of their territory. The defense made by this plan -- a contention which appears to have some merit -- is that certain of the other plans were not making strenuous or successful efforts to enroll the population of their areas. There are a number of other instances of plans serving the same areas.

The Commission approached these situations with caution. It recognized their disadvantages, but hesitated to enforce the standards upon the offending plans lest the net result be that the plans go on as before outside of rather than within the movement. Furthermore to give full title to a territory to a plan which was not successfully enrolling its population might satisfy the standards but impair service to the public. The Commission has temporized with these situations, has endeavored to persuade the plans to follow appropriate courses of action, and has been hopeful that in time the situations would work themselves out to a reasonably satisfactory solution. The new standards for reapproval do not specify that plans must serve exclusive areas or that they must serve areas of a size and character consistent with successful operation.

The Commission has been more successful in coping with this problem as regards new plans. It has on a number of occasions refused to give original approval to plans serving areas already served, or which could well be served, by existing plans. For example it denied approval to a non-profit plan operating in the Philadelphia area and steps to merge this plan with the Philadelphia plan are now underway. Since 1942 the Commission has refused to approve any new plan in a State not already served by a plan unless the plan had the intention and prospect of serving the entire State.

In West Virginia, which has a considerable number of local non-approved plans the Commission has granted approval only to two plans in the hope that eventually this State might be served by one or at the most two plans instead of by a multiplicity of local plans.

PLANS WITH POOR ENROLLMENT RECORD. The former standards made reapproval conditional upon the record of community service. There are a number of plans which over a period of years have shown very little growth. Examples are the Lynchburg, Virginia plan, which was established in 1938 and on January 1, 1947 had 7,913 members; the Danville, Illinois plan (established 1937, 11,760 members); the Watertown, New York plan (established 1937, 13,600 members); the Baton Rouge, Louisiana plan (established 1938, 14,100 members);

the Portsmouth, Ohio plan (established 1939, 22,800 members); the Newport News, Virginia plan (established 1938, 18,300 members); the Norfolk, Virginia plan (established 1935, 37,100 members); the Sacramento, California plan, the oldest of the Blue Cross plans, (membership 52,000). A number of other plans in the same category could be cited. ^{3/}

The Commission has been conscious of the problem posed by "weak" plans, but apparently has not been certain of the best remedy. To withdraw approval might result in nothing more than the plan going on as before. On the other hand, there is the possibility that by suggestion and persuasion these plans might voluntarily merge with stronger plans or become revitalized. Within the last few years a number of plans have merged with others. ^{4/}

In 1944 the Blue Cross Plan Approval Committee of the American Hospital Association (the functions of this Committee have now been taken over by the Commission) recommended to the Board of Trustees of the Association that certain of the plans be advised by the Commission that reapproval for 1945 would be contingent upon substantial increases in enrollment. It was further recommended that the Commission staff confer with these plans with a view to effecting wider community service through coordination, federation or consolidation with other plans, reconsideration of enrollment policies, rates and benefits, and clarification of enrollment areas served. The plans so advised were all of the plans in the States of California, Georgia, Illinois, Kentucky, and Virginia; the Baton Rouge, La., the Sioux City, Ia., plans, the three smallest plans in New York State, ^{5/} the Canton, Lima and Portsmouth plans in Ohio, and the Texas plan.

Although some of the plans so notified had little increase in enrollment in 1944 nevertheless all of these plans were reapproved for 1945. The Commission's concern with the problem was indicated at its March, 1945 meeting when it voted to request the Chairman of the Commission and the Chairman of the Approval Committee "to explore and recommend methods for more effective application of the standards of approval for Blue Cross plans."

In May 1945 the Commission recommended to the Board of Trustees that "no plan be approved for 1946, regardless of solvency, unless it has an enrollment of 25,000 as of January 1, 1946, or within three years from date of first approval, whichever is later, and that no plan be approved in January 1946, regardless of solvency, unless it has reached an enrollment equal to one percent of its population during each year of operation since first approval...."

The Board of Trustees referred these recommendations to the House of Delegates which after lengthy discussion postponed action. Discussion on the floor indicated sympathy with the objectives, but doubt as to the wisdom, of the proposed steps. Several speakers suggested that these plans needed an increased measure of help from the Commission; one went so far as to suggest

3/ A number of these and other plans serve such restricted areas that it is doubtful if they will ever have a good record of community service. Prime examples are the Jamestown and Watertown plans in New York State, each of which serves a single county of 115,000 and 77,000 people respectively; the Danville plan in Illinois which serves two counties with an aggregate population of less than 100,000; the Portsmouth plan in Ohio, and the Newport News plan and the Lynchburg plan in Virginia, each of which serves a single very moderate sized city. These plans manifestly ought to be merged with others.

4/ The Geneva, N.Y. plan merged with the Rochester plan in 1945; the Eliot Goodridge plan, a single Hospital plan, merged with the New Orleans plan in 1943, and the two Connecticut plans consolidated in 1944. The Peoria, Ill., plan merged with the Chicago plan in January 1947.

5/ One of these (Geneva) has since merged with another plan.

that the Commission should inject itself directly into these situations and should in effect temporarily take over the plan and put it on its feet.

The revised standards do not make reapproval conditional upon a record of community service. The change in the standards presumably indicates that the Commission and the American Hospital Association felt that the old standard was unenforceable, or that the problem was one which could not be successfully handled through the device of the approval program. In good part weak plans are weak because they do not have the support of the hospitals, or because the hospitals and the public of the area do not care sufficiently about the plans to have them otherwise. The prime requisite for a change in the situation is a change of attitude and a development of interest on the part of the hospitals or the public or both.

INTER-PLAN COORDINATION. The principles of organization state that the plans should coordinate their activities through uniform procedures, including transfer of members, reciprocal service benefits, uniform enrollment and billing procedures for national concerns and consolidated billing for such concerns when they desire it. The standards for reapproval do not mention these subjects.

There is great need for inter-plan coordination along these lines and the plans have made considerable progress in the development of such coordination.

The enrollment of national concerns would be facilitated if all the plans adopted a uniform contract either for all subscribers or employees of national concerns. Developments with respect to a proposed national uniform contract have been previously mentioned. The main difficulties in the way of adoption of uniform benefits are first, the differences in hospital and medical practices among communities (as a result of which some plans, for example, are able to offer x-ray services, others not), and secondly, the fact that the real goal in mind is comprehensive coverage and from this point of view standardization of coverage on any level short of this goal may not be desirable. Thus far the main accomplishments of discussions of a national uniform contract have been to encourage plans to increase the scope of benefits offered.

Workable arrangements for transfer of members between plans have been developed and all except two or three plans are cooperating in these arrangements.

The present program for reciprocity in provision of service benefits to subscribers hospitalized outside of the home plan area has the adherence of about one-third of the plans, these plans having two-thirds of the total enrollment. The plans which provide less comprehensive benefits than most or which operate in low cost hospital areas may have valid objections to the program on its present basis and some change in the nature of the program may be necessary. Obviously the operation of the program for those plans which desire to participate is hindered so long as there are other plans which refuse to participate.

The plan directors in their conferences have voted to adopt uniform enrollment regulations and billing procedures for national concerns and also to cooperate in the provision of consolidated billing for national concerns which desire this procedure. At present writing (March 1947) it is not known whether all of the plans have actually adopted the uniform enrollment and billing procedures for national concerns and are actually cooperating in consolidated billing arrangements, or not. It is suspected that some plans are in practice refusing to cooperate. Obviously such cooperation is vital if national concerns are to be satisfactorily served.

SOME OBSERVATIONS ON THE APPROVAL PROGRAM

This recital of the issues involved in the approval program serves to indicate some of the basic problems facing the movement. In the past it appears that the approval program has been administered by the Commission with considerable wisdom. The program has functioned largely as an educational device. Its influence in molding the plans to common patterns has been great. The Commission has steered a perilous course between on the one hand overlooking departures from the standards to the extent that the standards become meaningless and, on the other hand, exercising its putative authority in ways which would have had a disruptive effect upon the movement. Merely to have held the plans together has at times been an accomplishment. Always it must be held in mind that the movement is an association of locally controlled, independent and autonomous plans, and that the individual plans will suffer only so much direction or restraint from the national organization as will appear to carry to that individual plan a net residuum of advantages over disadvantages.

The present standards for reapproval require little of any plan: it must be non-profit, have representation of the hospitals, the medical profession and the public in its control, provide free choice of hospital. The requirements stress financial soundness but do not rigorously require it: the alternative to financial backing by the hospitals is not that the plan must have certain contingency reserves but that it must be in process of developing them. The present standards give the central organization of the plans no foothold by which to assure that any given plan is economically and efficiently administered, serves a suitable area, is performing an increasing measure of service to the public, is cooperating in inter-plan coordination services necessary for maximum service to the public.

From the above standpoint the September 1946 revision of the standards might seem to have been a step backwards, as if the teeth had been removed from the standards. However, in fact the old standards had only the semblance of teeth -- many of the old standards were not being enforced and were unenforceable. The present standards have the virtue of frankness. They pose starkly the problems confronting the plans.

It appears that the movement faces two basic problems. One is the reformulation of a philosophy. What is or should be the nature of the plans? The idea that the plans are organizations of the hospitals, that they should be controlled by them and financially backed by them apparently can no longer serve as the common denominator of the movement.

The other is the problem of plan sovereignty as over against the need for joint action and unified control.

The plans are only too well aware of these problems. There is keen recognition that somehow, someday the approval program needs to be strengthened and a stronger central organization developed.

A significant move was taken at the October 1946 conference. It was proposed that a new central organization to be known as American Blue Cross be created. The Hospital Service Plan Commission, shorn of all staff and funds, would be retained as the connecting link between the new organization and the American Hospital Association.^{6/}

^{6/} The new organization would not be part of the American Hospital Association.

The plans would be grouped into twelve districts, and the plans in each district would elect one representative to the governing board of the new central organization. Each district would have a council composed of representatives from the constituent plans. The whole idea of the proposal was to make the central organization more representative of the plans, more responsive to them, with the thought that only to a body so constituted would the plans delegate the powers that a central organization needed to have.

At a meeting in January 1947 the plans adopted much of this proposal.^{7/} However, instead of a new organization the Blue Cross Commission was revamped, as has been set forth earlier in this chapter.

By the time this account appears further changes in the nature of the central organization and of the approval program may have taken place. Events are moving so fast that no snapshot of the situation at any given movement has any real value. This account has endeavored to give some notion of the general background situation, the problems and the forces at work.

^{7/} The organization of the plans into districts has been carried out, and representatives of the plans in each district have been meeting together to elect their representative to the Commission and for discussion of common problems. In a few districts the plans have made considerable progress in developing closer coordination, common procedures, cooperation on enrollment, etc. Many plan directors regard this development as a most significant one and believe it will go much farther. If the plans in each district can develop close coordination with each other with regard to enrollment, transfer of members, inter-plan service benefits, consolidated billing, greater uniformity of benefits, etc., the ability of the plans to achieve the same coordination on a national basis will be increased.

PART II
MEDICAL PLANS

CHAPTER 14

THE DEVELOPMENT AND GROWTH OF MEDICAL SERVICE PLANS

This discussion of medical service plans is restricted to a particular type of plan, namely non-profit plans open to the general public of a particular State or locality, offering free choice of physician, and either sponsored by the medical profession or affiliated with a Blue Cross plan, or both. The first plans of this type were established in 1929-1935. But these early plans had relatively little influence on subsequent developments. New beginnings were made in 1939 and 1940. But not until 1943 did the movement really begin to gain impetus. The whole development is relatively new, and in many respects patterns have not yet crystallized.

THE RISE OF MEDICAL PLANS IN WASHINGTON AND OREGON

The first medical plans were established in various counties in Washington and Oregon. One plan was started as early as 1929, - indeed one report has it that a plan was started as early as 1917, - but most of them were established in 1931-1935. All these plans had a common background.

In both States during the latter part of the nineteenth and the early years of the present century, mines, railroads, sawmills and logging companies developed the practice of entering into contracts with physicians, hospitals, clinics and "hospital associations" for the provision of medical care to workers injured in the course of employment. The cost of these contracts was usually divided equally between employer and employee, the employee's share being deducted from pay. Later these practices were given formal recognition by the workmen's compensation laws of the two States.

In both Washington and Oregon a considerable number of private group clinics and so-called hospital associations, - some of which owned and others did not own hospitals, - developed to take such contracts. In most cases these organizations were started by physicians but later came under lay control. Gradually employers began to contract with these same organizations for ordinary medical care for their employees, the cost usually being met by the employees through payroll deductions.

By the late twenties an appreciable part of the medical care of wage earners in the two States had come under the control of these organizations, and the medical profession was feeling the effects. Abuses developed. The hospital associations were in a position to throw their work to designated hospitals and physicians, and, by playing one hospital and one physician off against another, they forced rates of remuneration to extremely low levels.

The general medical profession feeling the inroads of these organizations determined to "fight fire with fire". Beginning in 1929, and with greater impetus as the depression set in, one by one the county medical societies formed so-called medical service bureaus. Stock in these bureaus was owned by the participating physicians -- all physicians in the area being eligible to participate. The medical service bureaus contracted with employers for care of employees, the latter having free choice amongst all par-

ticipating physicians. The bureaus paid the hospitals, nurses, and suppliers of orthopedic equipment for their services in full; then they divided what was left among the participating physicians on a prorata fee basis.

For many years the operation of these bureaus was a source of much debate among the physicians of the two States. The whole idea of provision of care on a prepayment or "contract" basis was under suspicion. Since the bureaus solicited contracts, many physicians doubted that they were any more "ethical" than the commercial hospital associations or private clinics. Gradually, however, the bureaus won acceptance both among the profession and the public and began to outcompete the clinics and hospital associations.

At the present time in the State of Washington there are some 22 county medical service bureaus. An endeavor to merge these bureaus into a State-wide organization is under way. In Oregon all except seven of the county bureaus were merged in 1943 into a State-wide organization -- Oregon Physicians' Service.

All of these organizations provide a fairly comprehensive service for the employee: hospitalization, complete physicians' service (except for maternity care) in the office, home and hospital, special nursing when required, some orthopedic supplies. The charges range from \$1.75 to \$2.75 per month, possibly higher. Since 1944 coverage of varying scope has been extended to dependents. The bureaus in Washington generally do not accept employees with incomes over \$2500 annually. Oregon Physicians' Service has no such income limit.^{1/}

For some years the hospitals in Washington and Oregon have been dissatisfied with the medical service plans because (a) they had no share in the control of these plans, and (b) such slow progress was being made in the extension of hospital service on a prepayment basis to the whole population. Accordingly, in 1942 and 1943 the hospitals in the two States started their own Blue Cross plans. Bitter competition ensued between the two types of plans. Lately elements on both sides have recognized the disadvantages of this situation, but so far a basis of cooperation has not been found.

CALIFORNIA PHYSICIANS' SERVICE

By 1937 or 1938 the medical profession began to be aware that the public strongly desired to purchase medical care on a prepayment basis. The profession felt that it should endeavor to meet this demand. In 1938 the Governor of California sponsored a bill for compulsory health insurance. These two factors were primarily responsible for the establishment in 1939 of California Physicians' Service by the California Medical Association. The Association advanced \$42,000 to the plan as starting capital. In the beginning two contracts were offered, one at a cost of \$1.70 a month, which provided complete physicians' service, and a two-visit deductible contract, at a

^{1/} At the time of the field visit to these plans in January, 1945, most of them were not making aggressive enrollment efforts. The threat to private practice from the clinics and commercial hospital associations had largely been overcome, and under the then prevailing situation physicians felt that they stood to gain little from further expansion of the bureaus. During the war years, physicians had more patients than they could well take care of, and it was felt that prepayment would only swell the demand for medical attention. Perhaps more important was the fact that the fees paid by the bureaus were generally somewhat under prevailing charges to non-insured patients, and many physicians thought they could earn more from the same group of wage earners as non-subscribers than as subscribers. Since 1945 the plans have increased their fee schedules and it is understood that at present (March 1947) efforts to expand enrollment are being made.

cost of \$1.20 a month, which provided the same services but wherein the subscriber paid directly for the first two visits in any illness. Most of the contracts sold were of the first type. Subscription was limited to employed persons only -- it was hoped that coverage could be extended to dependents later. Only persons earning less than \$3,000 a year were accepted. (At the very beginning persons earning over this income level were accepted but with the proviso that physicians could charge them extra. This did not work out and in effect enrollment was limited to those earning less than \$3,000 a year.) Cooperative arrangements were entered into with the three hospital service plans in California providing for joint selling of the hospital and medical contracts and joint collection of the subscription charges. Control of CPS was vested in a Board of Trustees composed of ten physicians and one lay person.

Growth was slow. By January, 1940, CPS had 7,000 members; by January, 1941, 22,000; and by January, 1942, 40,000 members.

The experience, especially under the more comprehensive contract, was disastrous. The number of services demanded by subscribers far exceeded expectations, with the result that the plan had to reduce the compensation provided to physicians. Physicians were paid on a "unit" basis. The unit had a par value of \$2.50 which was the fee for an office visit, other services being priced at a multiple of this unit. The plan started off paying a unit value of \$1.75. This gradually declined. By January, 1940, it had decreased to \$1.50. It reached a low of \$1.10 in December of that year and remained rather constantly at \$1.25 through 1941.

A good many physicians in California had not been persuaded of the necessity of establishing CPS in the first place, and the organization did not have the united support of the profession. The decline in the unit value still further diminished enthusiasm. Many participating physicians resigned. Others refused to accept CPS patients without making an extra charge directly to the patient; some treated CPS patients as if they were charity patients. A considerable part of all CPS contracts had been sold in Alameda county to subscribers of the Oakland Blue Cross plan. Hence, the Alameda physicians suffered severely from the reduction of the unit value, and in 1942 a large group of these physicians resigned *en masse*.

Sale of the full coverage contract was stopped in the fall of 1941 and two contracts, one providing for surgical service and for x-ray and laboratory service while hospitalized, and a rider to the latter providing for obstetrics and for medical service on a two-visit deductible basis, were substituted. The surgical contract was offered to both employed persons and dependents; the medical rider was offered only to employed persons. Beginning in 1942 the full coverage contracts were cancelled out or converted to the limited contracts, and by 1943 the last of these contracts had been retired. The effect of this change, coupled with an increase in 1943 in the rates for newly enrolled groups, was reflected in the unit value which reached \$1.50 by the end of 1942, \$1.75 early in 1943, and \$2.25 in February 1944.

The limitation of enrollment to persons with incomes under \$3,000 was found to hinder public acceptance of the plan, and in 1942 special contracts on an indemnity basis were offered to persons having incomes over \$3,000. This did not fully solve the problem. In the press of mass selling, persons with incomes over \$3,000 often received the "service" contract, and physicians protested when they were compelled to accept CPS fees for these patients and could not charge extra. Accordingly, in 1944, the special indemnity contract for those with incomes over \$3,000 was done away with. One contract was sold

to all irrespective of income, and this contract provided that participating physicians would not make extra charges to those with incomes under \$3,000.

In 1942 the cooperative arrangements with the Blue Cross plans with headquarters in Oakland (Alameda County) and Sacramento broke down, owing in part to the then disaffection of the doctors in these areas with CPS. In order to protect themselves in competition with CPS and commercial companies these two plans developed their own surgical indemnity insurance riders which they sold in conjunction with their hospital contracts. CPS was also forced by the competitive situation to develop its own hospitalization contracts which it sold in the northern part of the State. The cooperative arrangement with the Blue Cross plan in the southern part of the State remained in force.

By the beginning of 1944 the general position of CPS had improved. The unit value had been raised to \$2.25, and this, based on a rather high fee schedule, was providing fairly satisfactory remuneration to the profession. In August, 1944, CPS repaid the loan of \$42,000 originally made by the State society. In 1945 numerous bills for compulsory health insurance were introduced in the State legislature. All of these developments caused the profession to give staunch backing to CPS and to encourage aggressive enrollment efforts.

Early in 1945 the plan raised its subscription rates (to \$3.00 for a family for the surgical contract and \$.90 for the individual for the medical rider). Despite this increased income the demand for service was such as to force the plan to reduce the unit value to \$2.00. The plan has not yet succeeded in attaining a stable basis of operation. Nevertheless firm support from the profession continues, and, under a new (lay) administrator, enrollment has steadily increased.^{2/}

MICHIGAN MEDICAL SERVICE

The Michigan State Medical Society has long believed that the profession should assume leadership in the development of arrangements for making medical care more available to the public. At a special session of the House of Delegates in January, 1939, the Council of the Society was empowered to cooperate with labor, industry and other groups in the formation of a non-profit group medical care organization. Before such a plan could be established, State enabling legislation was necessary. The hospitals of Michigan at this time were also desirous of starting a hospital plan. Together representatives of the hospitals and the medical profession asked for the necessary legislation, and in the spring of 1939 two acts, one enabling the formation of hospital plans, the other enabling the formation of medical plans, were passed.

The establishment of Michigan Medical Service was made possible by an advance of \$17,800 from the State society. The plan was controlled by a board of 35, all but 11 of whom were doctors of medicine. The plan had its own executive director and administrative staff, but a cooperative arrangement was entered into with Michigan Hospital Service, which had started operations some months previously, for enrollment and collection of subscription charges.

The plan first offered a contract for virtually complete medical service at charges of \$2.00 a month for an individual, \$3.50 for husband and wife and \$4.50 for a family. The subscriber paid directly for the first \$5.00 worth

^{2/} No mention in this account is made of CPS's housing or rural medical programs. These illustrate, probably, the good intentions of the plan, but the final results have not been significant.

of medical services in any contract year. This full contract was in existence from March, 1940 to July, 1942. It achieved a peak enrollment of only 10,000 persons. The public displayed little interest in it but showed infinitely keener interest in the surgical contract subsequently offered at a much lower cost. It was soon apparent that the charges under the comprehensive contract were insufficient to meet the costs, and the plan and the profession were not eager to push its sale.

When Michigan Medical Service opened its doors for enrollment early in 1940, Michigan Hospital Service was in the midst of negotiations with the Ford Motor Company for coverage of its employees. The company was not interested in complete care. It wanted a coverage which would take care of the catastrophic illness and would cost the employee not more than \$1.00 a month. The two plans developed contracts to meet this specification. Michigan Hospital Service offered a hospital contract at \$.60 a month for the single individual while Michigan Medical Service developed a contract providing surgical, obstetrical, x-ray, and anesthesia service for hospitalized bed patients at a cost of \$.40 a month for a single person, \$1.20 for husband and wife and \$2.00 for a family. It was agreed that participating physicians would accept the fees of the plan as full payment for their services in the case of single subscribers with incomes under \$2,000 a year and married subscribers with incomes under \$2,500.

These contracts were acceptable to the company and over 60,000 Ford employees were signed up within the month. By the end of six months, 78,000 Ford employees were enrolled. At the close of the contract year the Ford Company cancelled its coverage with the two plans and took out insurance with a commercial carrier. However, the plans during that year enrolled substantial numbers of General Motors and Chrysler Corporation employees, and by January 1, 1942, Michigan Medical Service's enrollment stood at 450,000.

The plan had a favorable experience with the Ford group but lost money on its other groups and on the comprehensive contract, so that by the end of 1942 it had a deficit of \$439,000. To meet this situation rates were increased in 1941 and again in 1942.

Continued operation of the plan during 1941 and 1942 despite the mounting "book" deficit was made possible by two devices. From April to September, 1941, the plan prorated and paid participating physicians only 80 percent of what was due them. The effect of this was bad. Physicians tended to lose faith in the plan. Officials of the plan state that, when proration was stopped and payment on the full fee schedule resumed, it was as if the plan had received a blood transfusion.

The second device resorted to was delay in the payment of doctors' bills. In July, 1942, physicians' bills were being paid on an average time interval of 33 days between receipt of bill and mailing of the check. By November, 1942, this time interval had increased to 60 days.

On the rates introduced in 1942 Michigan Medical Service was able to put its financial house fully in order. Since then the deficit has been erased, the lag in payment of physicians' bills has been eliminated, the amounts -- aggregating \$127,000 -- withheld from the physicians during the period of proration have been paid back, and a substantial reserve has been accumulated. In the spring of 1945, benefits to subscribers were increased somewhat.

During the period of financial difficulties the plan curbed new enrollment -- indeed the State insurance department prohibited it from taking on new groups. The bar to new enrollment was partially lifted in the fall of

1943 and fully lifted in the spring of 1944. Since then enrollment has substantially increased.

OTHER PLANS ESTABLISHED IN 1940

The growing interest of the medical profession and the public in prepayment medical plans was shown by the passage in 1939 of enabling acts for medical service plans in the States of Connecticut, New York, Pennsylvania, and Vermont -- as well as in Michigan. In the following year plans were started in two of these States, - in Buffalo and Utica, New York, and in Pennsylvania.

The profession took the lead in the establishment of the two New York plans with the thought that just as hospital plans had been mutually advantageous to the public and the hospitals, so prepayment medical plans would be mutually advantageous to the public and the profession. In both instances the establishment of the plans was materially aided by the existence of Blue Cross plans to which responsibility for administration of the medical plans could be and was delegated.

In both Buffalo and Utica the profession was convinced that public demand and need could be met only by the provision of comprehensive service, and both plans were consequently started on this basis. The Buffalo plan at the outset or soon after also offered a limited surgical contract, but this had a very small enrollment compared with the comprehensive contract. The Buffalo plan was on a "service" basis for subscribers under certain income limits, i. e., for subscribers under these income limits the participating physicians agreed to take the plan's fees as full payment for their services and not to make extra charges to the subscribers. The Utica plan was on a service basis for all subscribers irrespective of income.

Both plans provided for a certain degree of co-insurance, in that subscribers were to pay directly for, or share the cost of, the first few calls in any illness. Neither plan functioned successfully on the original basis. In both cases the demand for service exceeded expectations, and proration of fees had to be resorted to. Both plans encountered problems in the control of a few physicians who made excessive numbers of calls on their patients. The Utica physicians were dissatisfied because they felt that the plan had enrolled a disproportionate number of well-to-do persons -- persons who would ordinarily be charged higher fees than those paid by the plan. In Buffalo, the discrimination in benefits between subscribers over and under the income limits -- the plan was administered so as to necessitate information on incomes from the employer or the employee -- caused difficulties. In Utica public response to the plan was disappointing; people thought that the charges were high for what the plan provided.

It was not long before changes were made in both plans. After about a year the Utica plan brought forth a limited service contract (surgery, obstetrics, x-ray, laboratory and anesthesia services for hospitalized patients) at a cost about half of that for the comprehensive contract. This contract was on a straight "indemnity" basis, i. e., the plan provided stipulated fees for the different services and physicians could make extra charges if they desired. ^{3/} This contract proved popular with both the public and the profes-

^{3/} The term "indemnity" may perhaps not be the best term to describe this arrangement. In medical economics the term indemnity has often been used to denote arrangements where the payment is made directly to the patient. Under most of the present non-profit plans on a so-called indemnity basis, the payment is made directly to the physician. Under the other plans the check is usually made out to both the physician and the patient jointly and is sent to the patient. However, the latter may assign his benefits to the physician in which case the check is sent to the latter. The real difference between "service" and "indemnity" plans is that under the first physicians cannot charge extra, while under the second they can.

sion; it was also successful financially. Soon after the comprehensive contract was discontinued, and a "medical call" rider to the surgical contract covering hospital calls in medical cases was offered. These two contracts have been successful, and enrollment has steadily increased.

In Buffalo, early in 1943, new comprehensive and surgical contracts were offered. These were on a straight indemnity basis. The new comprehensive contract did away with the co-insurance features but placed limits on the number of calls to which a subscriber would be entitled in any one year. The new features plus a slight increase in rates permitted the plan to pay the full scheduled fees on the new contracts, although proration was continued on the old. Sale of the old type contracts was discontinued and gradually these have been liquidated. For a while all went well and enrollment increased. Contrary to the experience elsewhere the public showed much greater interest in the comprehensive contract (selling at \$3.00 a month for a family) than in the limited surgical contract (\$1.70 a month for a family) and the former far outsold the latter. However, in 1945 the experience with the comprehensive contract turned unsatisfactory and the plan was forced to discontinue its sale.

The original Pennsylvania enabling act permitted the enrollment only of persons with incomes under certain limits. The State society organized a plan which had its own director and administrative staff but which entered into cooperative relationships with the Pittsburgh hospital service plan for enrollment and billing. Although it had been the intention at first to offer a comprehensive service, the experience of other plans warned against this, and a limited contract providing surgical and obstetrical services only was offered. It was found that the restriction of enrollment to persons with incomes under the specified level crippled enrollment efforts, and in 1943 the State society sponsored an amendment to the medical service plan act permitting enrollment of all persons regardless of income. Following this step, enrollment has been offered to all, participating physicians being free to make extra charges to persons over certain income limits.

Up until 1944 the plan was not vigorously pushed by the State Society, since then it has been. The cooperative relations with the Pittsburgh Blue Cross plan broke down and thus far (March 1947) the plan and the Blue Cross plans of the State have been unable to agree on a mutually satisfactory basis of cooperation. Thus far growth has been small.

A medical plan was also established in 1940 in North Carolina. In that year, Hospital Care Association, one of the two competing Blue Cross plans in the State, organized a medical service adjunct known as Medical Service Association. This organization had its own board of directors but otherwise was administered by the hospital plan. The plan enrolled members only in counties where its operations were indorsed by the county medical society. A contract offering stipulated allowances for surgical and obstetrical services and hospital calls was offered. In 1943 Hospital Care Association began to offer a surgical indemnity rider to its hospital contract, thus transforming itself into a joint hospitalization and medical plan. Since then it has pressed the sale of its own surgical contract rather than the contracts of its medical adjunct. It has, however, continued to use Medical Service Association as a vehicle for the extension of special low cost contracts to Farm Security Administration borrowers.

PLANS ESTABLISHED IN 1941, 1942 AND 1943

The increasing interest of the medical profession and the public in medical prepayment was shown by the passage of enabling legislation in four States - Massachusetts, New Jersey, Ohio and Virginia - in 1940 and 1941 and by four States in 1943. Although a few plans have been started without the benefit of legislation, in most States the establishment of medical plans, as with hospital plans, has had to wait upon the passage of enabling legislation. In some States the legislation permits the establishment of separate medical service plans; in other States it permits either separate plans or plans which can provide both hospital and medical prepayment.

At this point cognizance should be taken of a new force which from 1940 on has played an important role in the establishment of medical plans. This new force is the Blue Cross plans. These plans have two interests in the formation of allied medical plans or in the transformation of themselves into joint hospital and medical plans. In the first place, the plans are under pressure from their subscribers. The subscribers, in effect, tell them: "Since a plan covering hospital services works so well, why cannot a similar arrangement be developed for physicians' services?" Secondly, the plans in selling hospital service contracts are in competition with commercial insurance companies which in 1939 or 1940 began to offer surgical coverage along with their hospitalization policies. From 1941 on the plans increasingly found that their inability to offer surgical coverage handicapped them in competition with the commercial companies.

Since 1940 or 1941 the directors and board members of Blue Cross plans have interested themselves more and more in the establishment of medical plans. In a few places these men stimulated groups of physicians to think about the problem, and the latter in turn then led their medical society to take action. Often Blue Cross administrators, being experienced in this field and having the necessary data at their command, aided the medical society by developing the actuarial basis for the proposed plan. In a few places where the medical profession was not greatly interested in the establishment of a plan, the hospital plan carried the major burden in the work of organizing and establishing a plan, even supplying the necessary capital. Where the medical society was definitely and enthusiastically interested, then the establishment of a plan often became in reality a cooperative endeavor of the society and the Blue Cross plan.

Practical considerations -- the ease of selling medical coverage to the already enrolled members of the hospital plan and the disinclination of employers to make payroll deductions for two separate organizations -- made co-operation between hospital and medical plans almost an absolute necessity. Hence, except in northern California, Oregon, Pennsylvania and Washington, all of the medical plans have been allied with the existing hospital plan or plans serving the same territory. The device usually adopted was for the medical plan to be set up as a separate corporation with its own board of directors, but to contract for administration with the Blue Cross plan, the same individual serving as executive director of both plans.

Plans were started in 1941 and 1942 in five States (in addition to California where two of the hospital service plans extended their coverage to include physicians' services). In two instances, North Carolina and New York City, the major role in establishment of the medical plan was played by the

existing Blue Cross plan. In three other States - Colorado, New Jersey and Massachusetts -- all or most of the initiative came from the medical profession.

In 1941, Hospital Saving Association of North Carolina, the larger Blue Cross plan in the State, which is controlled by a board on which the hospitals, the medical profession and the public have equal representation, began to feel the need of offering medical service benefits in order to meet the competition of the other Blue Cross plan in the State and of commercial companies. Accordingly, the plan began to offer a surgical indemnity contract along with its hospital contract. The reserve of the hospital plan served as a reserve for the surgical benefits as well; the plan was not underwritten by the profession.

The plan developed late in 1942 by the New York City Blue Cross plan followed, in a sense, a similar pattern. The Blue Cross plan wanted to develop a medical contract both to satisfy public demand and to meet competition from commercial insurance companies. The medical profession in New York City was not anxious to start a plan. The profession was willing to see service benefits guaranteed only to persons with incomes under \$2500, whereas the officials of the plan thought the income limit for service benefits should be placed at \$3500. Unable to secure agreement the plan went ahead and formed its own medical adjunct. (The New York law prohibits one plan from offering both hospital and medical benefits, although a hospital or medical plan could act as agent for the other.) The medical plan had its own board of directors but had no staff of its own and was administered entirely by the Blue Cross plan. A limited surgical contract on a straight indemnity basis was offered.

Late in 1944 a compromise agreement was reached with the medical profession over the issue of the income limit for service benefits. It was agreed that participating physicians would not make extra charges to single persons and families with incomes under \$1800 and \$2500, respectively, and that persons in families with incomes between \$2500 and \$3500 if they were charged extra and wished to protest might appeal to a committee for review of the charge. Thereupon the medical profession agreed officially to sponsor the medical plan, and the plan offered new contracts incorporating the above provisions relative to service benefits. It continued, however, to offer the old straight indemnity contracts.^{4/}

In the case of the plans started in 1942 in New Jersey, Massachusetts, and Colorado, primary initiative came from the State medical association. The State society in New Jersey advanced \$5,000 and in Massachusetts \$25,000 as starting capital. Both plans were started on a service-indemnity basis. The New Jersey plan at first provided that patients who took ward or semi-private accommodations would not be subjected to extra charges. Physicians objected to this, and after a time the plan adopted the more common provision that patients with incomes under certain limits would not be charged extra, with the added proviso that subscribers, regardless of income, who voluntarily took private rooms, could be charged extra.

The Colorado plan initially limited enrollment to persons under certain income limits. This proved unworkable and for two years the plan made little progress. In 1944 the restriction was removed and the plan began really to function.

^{4/} Until late in 1946.

In 1943 three plans were started, - in Delaware, Kansas City, Mo., and Charleston, W. Va. All three offered a limited surgical contract. The Delaware and Charleston, W. Va.,^{5/} plans were on a straight indemnity basis; the Kansas City, Mo. plan offered a service contract to those under a given income limit and an indemnity contract to those above this limit. The Kansas City and Charleston plans had separate boards but were administered by the hospital plan. In Delaware no separate board was created, and the existing hospital plan, with which the Delaware medical profession was well pleased, simply issued surgical contracts and thus transformed itself into a joint hospital and medical plan.

RECENT DEVELOPMENTS

From 1944 on, the development of medical plans has gone ahead with increased impetus. In 1944 three plans were launched, in 1945, 10 plans, in 1946, 12 plans. Furthermore from 1944 on, enrollment in the older plans, some of which had for a period been quiescent, began rapidly to increase.

The operation of existing plans, chiefly Michigan Medical Service, had served to convince the medical profession that medical prepayment was workable, sound, and in the interests of both the public and the profession. The profession everywhere had become convinced that the public wanted the opportunity of obtaining medical service on a prepayment basis, and that it (the profession) should endeavor to meet that demand. The Wagner-Murray-Dingell bill and other proposals for compulsory insurance also served to spur the profession to action. From 1943 on the American Medical Association actively encouraged State and local medical societies to establish plans. Public response to existing plans and the live interest of the Blue Cross plans were also factors in the rapid development of the movement.

Most of the plans started since 1944 follow the conventional pattern of a non-profit service plan organized under special enabling legislation, and with control firmly vested in the medical profession. However, several of the plans serve to illustrate the varied forces now active in this field.

The Ohio enabling act for medical plans, passed in 1941 at the instigation of the medical profession, contained an ironclad prohibition against any plan enrolling persons with incomes over \$2400 a year. This has prevented the establishment of medical plans on the usual basis. The need for a companion medical plan to the successful hospital plan in Cleveland had long been recognized. To meet this need outstanding civic and industrial leaders in Cleveland late in 1945 organized Medical Mutual of Cleveland, as a mutual insurance company. Capital to start the plan was advanced by these civic and industrial leaders and by a philanthropic foundation. The plan has its own executive director, but enrollment is conducted through the Blue Cross plan, and contracts are offered only to those who have the Blue Cross coverage.

Shortly after establishment of Medical Mutual of Cleveland the medical profession of Ohio launched its own plan - Ohio Medical Indemnity, Incorporated. This plan is organized as a stock insurance company. Capital was provided by the sale of preferred stock to the profession. Holders of this stock will receive dividends at five percent, but the stock will be retired

^{5/} It is understood that there are 10 hospital and 9 medical service plans now operating in the State. Only 2 of the hospital plans are approved Blue Cross plans and information has been obtained only about the medical plans affiliated with the 2 Blue Cross plans.

out of the earnings of the company as rapidly as possible. The common stock on which no dividends are payable is held by the State medical society. This plan has entered into cooperative relations with the Cincinnati and Toledo Blue Cross plans and aims to develop similar arrangements with the other plans.^{6/}

In New York City in 1945 a group of civic and medical leaders, among whom was Mayor La Guardia, formed an organization known as the Health Insurance Plan of Greater New York. Funds to permit preliminary organization were secured from a number of foundations. The plan will provide a comprehensive medical service through medical groups, and it has stimulated the formation of 18 such groups some of the groups being affiliated with hospitals, some not. Hospitalization will be obtained through the Blue Cross plan. The plan, which does not have the endorsement of the medical societies of the city, began enrollment in January 1947.

In a number of States the medical profession was for a period reluctant to establish its own plan and gave consideration to an arrangement whereby insurance companies would provide policies with fee schedules approved by the society, and physicians would then agree to accept these fees as full payment for their services in the case of patients with incomes under certain amounts. Arrangements of this nature were at one time decided upon in Wisconsin and Illinois but the profession in both States has since reconsidered and has decided to establish its own plan or plans. In Connecticut the State Medical Society has voted to encourage insurance companies to offer medical insurance rather than to develop a plan of its own.

A recital of the history of medical plans would perhaps not be complete without touching upon the developments set forth above. Yet it should be emphasized that these have been atypical. The main current has been the organization by the medical profession of plans under special enabling legislation.

The growth in number of plans and in enrollment has been as follows:

<u>Period</u>	<u>Number of Plans ^{1/}</u>	<u>Total Enrollment ^{2/}</u>
Jan. 1, 1940	3	167,000
Jan. 1, 1941	8	370,000
Jan. 1, 1942	10	775,000
Jan. 1, 1943	15	965,000
Jan. 1, 1944	19	1,235,000
Jan. 1, 1945	22	1,768,000
Jan. 1, 1946	32	2,535,000
Jan. 1, 1947	44	4,436,000

^{1/} The various county plans in Washington are counted as a single plan and the same is true of Oregon Physicians' Service and its affiliated plans.

^{2/} Data for the years 1940-44 includes estimated figures for some plans.

COORDINATING AGENCY AND ROLE OF THE AMERICAN MEDICAL ASSOCIATION

In 1943 the then existing medical plans formed a central organization known as the Medical Service Plans Council of America. This organization had no paid staff, and it served mainly as an agency to call meetings of adminis-

^{6/} As of May 1947 the plan had entered into cooperative arrangements with almost all of the Blue Cross plans except the Cleveland plan.

trators of the plans from time to time. Under the aegis of this organization several of the medical plans adopted as their symbol a Blue Shield and called themselves Blue Shield plans, and this example has subsequently been followed by a good many of the medical plans.

Throughout 1944 and 1945 the Council on Medical Service and Public Relations of the American Medical Association served in some respects as a coordinating agency of the existing medical plans, and endeavored to give guidance to local and State medical societies in the establishment of new plans. The attitude of the American Medical Association toward prepayment medical plans was rather definitely and firmly crystallized by passage of a resolution by the House of Delegates in December 1945 which instructed the Board of Trustees and the Council on Medical Service and Public Relations,

"to proceed as promptly as possible with the development of a specific national health program with emphasis upon the nation-wide organization of locally administered prepayment plans sponsored by medical societies."

At a meeting of medical plans held in February 1946 under the sponsorship of the American Medical Association a new central coordinating agency known as Associated Medical Care Plans, Inc., was formed. This organization will aid in the establishment of new plans, collect and circulate statistics, stimulate the development of arrangements for transfer of members and reciprocity of benefits among the plans, and in general perform the same functions as the Blue Cross Commission performs for the hospital plans.

Later in 1946 the Council on Medical Service and Public Relations of the A. M. A. announced tentative standards of approval for medical plans. Plans approved by the Council are entitled to display the Seal of Acceptance of the American Medical Association on their contracts and literature. As of February 1947 the Council had approved 52 plans.^{7/} The Seal of Acceptance is a circle within which is a Blue Shield emblazoned with a caduceus and the letters "A.M.A."

^{7/} Includes 22 plans in Washington, 5 plans in Oregon and 4 in West Virginia.

CHAPTER 15

PRESENT PLANS, AREA AND POPULATION SERVED

As of January 1, 1947, 44 medical plans were in operation. This includes nine joint hospital-medical plans.^{1/} Table 21 lists the plans, shows the area served and gives other relevant data. (Appendix M gives the address of each plan and the name of the Executive Director.)

Of the 44 plans 24 serve an entire State, one serves two States (New Hampshire and Vermont) and 19 serve local areas within States.^{2/} Relatively more of the medical than of the hospital plans are on a state-wide basis. At the present time, (January 1, 1947) 20 States are served by a single State-wide plan; one State (California) is served by a State-wide plan and by two local plans which compete with it; another State (North Carolina) has three state-wide plans, one of which serves Farm Security borrower families exclusively, and the other two of which compete with each other; another State (Oregon) has two competing state-wide plans; four States are served by local plans which together serve the entire State; four States have one or more local plans which together do not serve the entire area of the State, and 17 States and the District of Columbia have no plan at all. Such is the present tempo of activity in this field that in another year or two plans will be in operation in most or all of the States now without them.

Of the 44 plans 16 offer coverage of surgery and obstetrics only (and x-ray, pathology and anesthesia services where these are not offered by the allied hospital plan), 22 go further and provide coverage of physicians' services in the hospital for medical cases and six plans go still further and provide some coverage of physicians' service in the office and home.

Of the 44 plans, four are on a straight service basis, 17 on a mixed service-indemnity basis and 23 on a straight indemnity basis. In point of enrollment, 9 percent of the total number of people served are in the service plans, 62 percent in the service-indemnity and 29 percent in the indemnity plans.

The relationships between the medical plans and the Blue Cross plans serving the same territory run the gamut all the way from no relationship or even outright competition to that in which the two plans are one and the same, i. e., one plan issues both medical and hospital contracts.

The most common relationship, which exists between 20 allied medical and hospital plans, is that in which the two plans though established as separate corporations, each with its own board of directors, are completely unified administratively, i. e., the same individual serves as executive director for both plans and there is a single staff. Administrative expenses are shared

^{1/} The county medical bureaus in Washington which are in the process of being coordinated into a state-wide organization known as Washington Medical Bureau, are here considered as if they were one plan. Likewise Oregon Physicians' Service and its affiliated county bureaus are also considered as if they were one plan. There are a few plans in West Virginia which are not included in this count.

^{2/} Ohio Medical Indemnity, Inc. and Louisiana Physicians' Service both of which are state-wide in intention but at present are operating only in local areas, are here counted as local plans.

**Medical Service Plans, Area Served, Date of First Enrollment, Scope of Benefits, Type of Benefits,
Relationship with Hospital Plan, Enrollment, and Percent of Hospital Plan Members
Enrolled in Medical Plan.**

Data as of January 1, 1947

STATE	NAME OF PLAN AND HEADQUARTERS CITY	AREA SERVED	DATE OF FIRST ENROLLMENT	SCOPE OF BENEFITS (SEE CODE)	TYPE OF BENEFITS (SEE CODE)	RELATIONSHIP WITH HOSPITAL PLAN (SEE CODE)	ENROLLMENT	PERCENT OF HOSPITAL PLAN MEMBERS ENROLLED IN MEDICAL PLAN
ALABAMA	HOSPITAL SERVICE CORP. OF ALABAMA, BIRMINGHAM	STATE-WIDE	1945	2	I	C	45,791	26.2
ARKANSAS	NO PLAN							
ARIZONA	NO PLAN							
CALIFORNIA	CALIFORNIA PHYSICIANS' SERVICE, SAN FRANCISCO	STATE-WIDE	SEPT. 1939	4	S-I	B-D	419,672	1/
	HOSPITAL SERVICE OF CALIFORNIA, OAKLAND	9 COUNTIES - BAY AREA	1942	2	I	C	116,653	59.4
	INTERCOAST HOSPITAL INSURANCE ASSOCIATION, SACRAMENTO	39 COUNTIES - NORTHERN CALIFORNIA	1941	2 2/	I	C	37,221	71.7
	COLORADO MEDICAL SERVICE, INC., DENVER	STATE-WIDE	MAY 1942	1	S-I	A	174,132	41.9
CONNECTICUT	NO PLAN							
DELAWARE	GROUP HOSPITAL SERVICE, WILMINGTON	STATE-WIDE	MAY 1943	1	I	C	100,983	77.1
DISTRICT OF COLUMBIA	NO PLAN							
FLORIDA	FLORIDA MEDICAL SERVICE CORP., JACKSONVILLE	STATE-WIDE	1946	1	S-I	A	2,919	4.0
GEORGIA	NO PLAN							
IDAH0	NO PLAN							
ILLINOIS	MUTUAL MEDICAL INSURANCE, INC., INDIANAPOLIS	STATE-WIDE	1946	1,2	I	A	82,531	36.7
INDIANA	IOWA MEDICAL SERVICE, DES MOINES	STATE-WIDE	SEPT. 1945	1,2	S-I	B	17,214	4.2
IOWA	KANSAS PHYSICIANS' SERVICE, TOPEKA	STATE - EXCEPT KANSAS CITY AREA	JAN. 1946	2	S-I	A	14,558	6.7
KANSAS	NO PLAN							
KENTUCKY	LOUISIANA PHYSICIANS SERVICE, INC., NEW ORLEANS	STATE-WIDE (BUT NOT NOW OPERATING IN NEW ORLEANS AREA)	1946	1	S-I	B	5,972	19.8
LOUISIANA	HOSPITAL SERVICE OF NEW ORLEANS, NEW ORLEANS	21 PARISHES - SOUTHERN LOUISIANA	JUNE 1945	1	I	C	15,412	12.2
MAINE	NO PLAN							
MARYLAND	NO PLAN							
MASSACHUSETTS	MASSACHUSETTS MEDICAL SERVICE, BOSTON	STATE-WIDE	1942	2	S-I	A	461,000	23.2
MICHIGAN	MICHIGAN MEDICAL SERVICE, DETROIT	STATE-WIDE	MARCH 1940	1,2	S-I	B	850,000	72.8
MINNESOTA	NO PLAN							
MISSISSIPPI	NO PLAN							
MISSOURI	SURGICAL CARE INC., KANSAS CITY	GREATER KANSAS CITY AND NORTHEASTERN MISSOURI	JUNE 1943	1,2	S-I	A	115,000	62.2
	MISSOURI MEDICAL SERVICE, ST. LOUIS	STATE - EXCEPT AREA SERVED BY KANSAS CITY PLAN	1945	2	I	A	66,049	8.9
MONTANA	MONTANA PHYSICIANS' SERVICE, HELENA	STATE-WIDE	1946	2	S-I	B	8,996	16.3
NEBRASKA	NEBRASKA MEDICAL SERVICE, OMAHA	STATE-WIDE	NOV. 1944	2	I	A	21,540	26.6
NEW HAMPSHIRE	NEW HAMPSHIRE-VERMONT PHYSICIAN SERVICE, CONCORD, N.H.	NEW HAMPSHIRE AND VERMONT	AUG. 1944	1,3	I	A	85,370	43.3
NEW JERSEY	MEDICAL-SURGICAL PLAN OF NEW JERSEY, NEWARK	STATE-WIDE	JULY 1942	2	S-I	B	88,088	9.5
NEW MEXICO	NEW MEXICO PHYSICIANS' SERVICE, ALBUQUERQUE	STATE-WIDE	1946	2	S-I	B OR A	2,583	29.7
NEW YORK	WESTERN NEW YORK MEDICAL PLAN, BUFFALO	7 COUNTIES - WESTERN NEW YORK	1940	1	I	A	102,438	24.3
	UNITED MEDICAL SERVICE, NEW YORK CITY	SOUTHEASTERN NEW YORK	DEC. 1942	1,2	S-I	A	405,744	14.6
	GENESEE VALLEY MEDICAL CARE INC., ROCHESTER	6 COUNTIES - ROCHESTER AREA	1946	1	I	A	11,700	3.7
	CENTRAL NEW YORK MEDICAL PLAN, SYRACUSE	10 COUNTIES IN CENTRAL NEW YORK	1945	1,3	I	A	10,078	4.4
	MEDICAL AND SURGICAL CARE, UTICA	15 COUNTIES IN NORTH-CENTRAL NEW YORK	APRIL 1940	1,2	I	A	68,514	50.4
NEVADA	NO PLAN							

TABLE 21

Medical Service Plans, Area Served, Date of First Enrollment, Scope of Benefits, Type of Benefits, Relationship with Hospital Plan, Enrollment, and Percent of Hospital Plan Members Enrolled in Medical Plan
Data as of January 1, 1947

STATE	NAME OF PLAN AND HEADQUARTERS CITY	AREA SERVED	DATE OF FIRST ENROLLMENT (SEE CODE)	SCOPE OF BENEFITS (SEE CODE)	TYPE OF BENEFITS (SEE CODE)	RELATIONSHIP WITH HOSPITAL PLAN (SEE CODE)	ENROLLMENT	PERCENT OF MEMBERS ENROLLED IN MEDICAL PLAN
NORTH CAROLINA	HOSPITAL SAVING ASSOCIATION, CHAPEL HILL HOSPITAL CARE ASSOCIATION, DURHAM	STATE-WIDE	AUG. 1941	1	1		10,000	10.4
NORTH DAKOTA	MEDICAL SERVICE ASSOCIATION, DURHAM 3/	STATE-WIDE	MAY 1943	1	1		10,000	4
	NORTH DAKOTA PHYSICIANS SERVICE, FARGO	STATE-WIDE	1940	1,3	1	A	10,000	4
	MEDICAL MUTUAL OF CLEVELAND, CLEVELAND	STATE-WIDE	1946	1	1	A	6,000	4.4
	OHIO MEDICAL INDEMNITY, COLUMBUS	5 COUNTIES - NORTHEASTERN OHIO (NOW OPERATING IN CINCINNATI AND TOLEDO AREAS ONLY)	JUNE 1945	1	1	B	46,400	4.4
OKLAHOMA	OKLAHOMA PHYSICIANS' SERVICE, TULSA	STATE-WIDE	FEB. 1946	1	1	B	71,800	8.4
OREGON	OREGON PHYSICIANS' SERVICE AND AFFILIATED COUNTY BUREAUS, PORTLAND	STATE-WIDE	JUNE 1945	1	1	A	20,283	11.4
PENNSYLVANIA	NORTHWEST HOSPITAL SERVICE PLAN, PORTLAND	STATE-WIDE	1929	5	1	C	92,000 5/	2
	MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, HARRISBURG	STATE-WIDE	1946	2	1	C	4,741	7.4
	NO PLAN	STATE-WIDE	OCT. 1940	1,2	3-1	C	55,000 2	2
RHODE ISLAND	NO PLAN							
SOUTH CAROLINA	NO PLAN							
SOUTH DAKOTA	NO PLAN							
TENNESSEE	NO PLAN							
TEXAS	GROUP MEDICAL AND SURGICAL SERVICE, DALLAS	STATE-WIDE	1945	2	1	A	27,242	13.4
UTAH	MEDICAL SERVICE BUREAU OF THE UTAH STATE MEDICAL ASSOCIATION, INC., SALT LAKE CITY	STATE-WIDE	1946	1	3-1	B OR A	4,644	5.3
VERMONT	SERVED BY NEW HAMPSHIRE-VERMONT PLAN							
VIRGINIA	VIRGINIA MEDICAL SERVICE ASSOCIATION, RICHMOND	EASTERN AND CENTRAL VIRGINIA	1945	2	3-1	A-B	72,969	22.4
WASHINGTON 2/	SURGICAL CARE INCORPORATED, SEATTLE	WESTERN VIRGINIA	NOV. 1945	1	3	A	42,070	18.3
	WASHINGTON MEDICAL BUREAU AND AFFILIATED COUNTY PLANS, SEATTLE 2/	STATE-WIDE 2/	1933	5	3	C	250,000 2/	2
WEST VIRGINIA	MEDICAL SERVICE, INCORPORATED, CHARLESTON	9 COUNTIES IN CENTRAL WEST VIRGINIA	NOV. 1943	2	1	A	27,000 2/	47.4
WISCONSIN	HUNTINGTON HOSPITAL SERVICE, HUNTINGTON	7 COUNTIES IN WESTERN WEST VIRGINIA	1944	1	1	C	3,742	1.4
	SURGICAL CARE, MILWAUKEE	MILWAUKEE	1946	2	3-1	A	66,900	11.4
WYOMING	NO PLAN							

FOOTNOTES

- 1/ Surgical and obstetrical benefits with or without coverage of x-ray, anesthesia and laboratory services.
- 2/ Same as type 1 plus hospital calls in medical cases.
- 3/ Calls in home, office and hospital for medical cases.
- 4/ Comprehensive physicians' services, including obstetrical care, to employed persons. Only surgical service available to dependents.
- 5/ Comprehensive physicians' services (except obstetrics) for employed subscribers. Service available to dependents varies from none to comprehensive.
- 6/ Medical Plan members and Blue Cross members are not the same persons.
- 7/ There are 22 county medical service bureaus, all of which have been accepted by the A.M.A. An effort to merge these into a State-wide plan is underway. The bureau in Yakima County co-operates with the Blue Cross plan. The bureau in Clark County (Vancouver) cooperates with the Oregon Blue Cross plan.
- 8/ In addition to the plans listed there are seven other plans with a total enrollment of about 43,000. Headquarters of these plans are at: Clarksburg, Fairmont, Morgantown, Parkersburg, Weston, Wheeling and Williamson.

AREAS SERVED BY MEDICAL SERVICE PLANS,

JANUARY 1, 1947

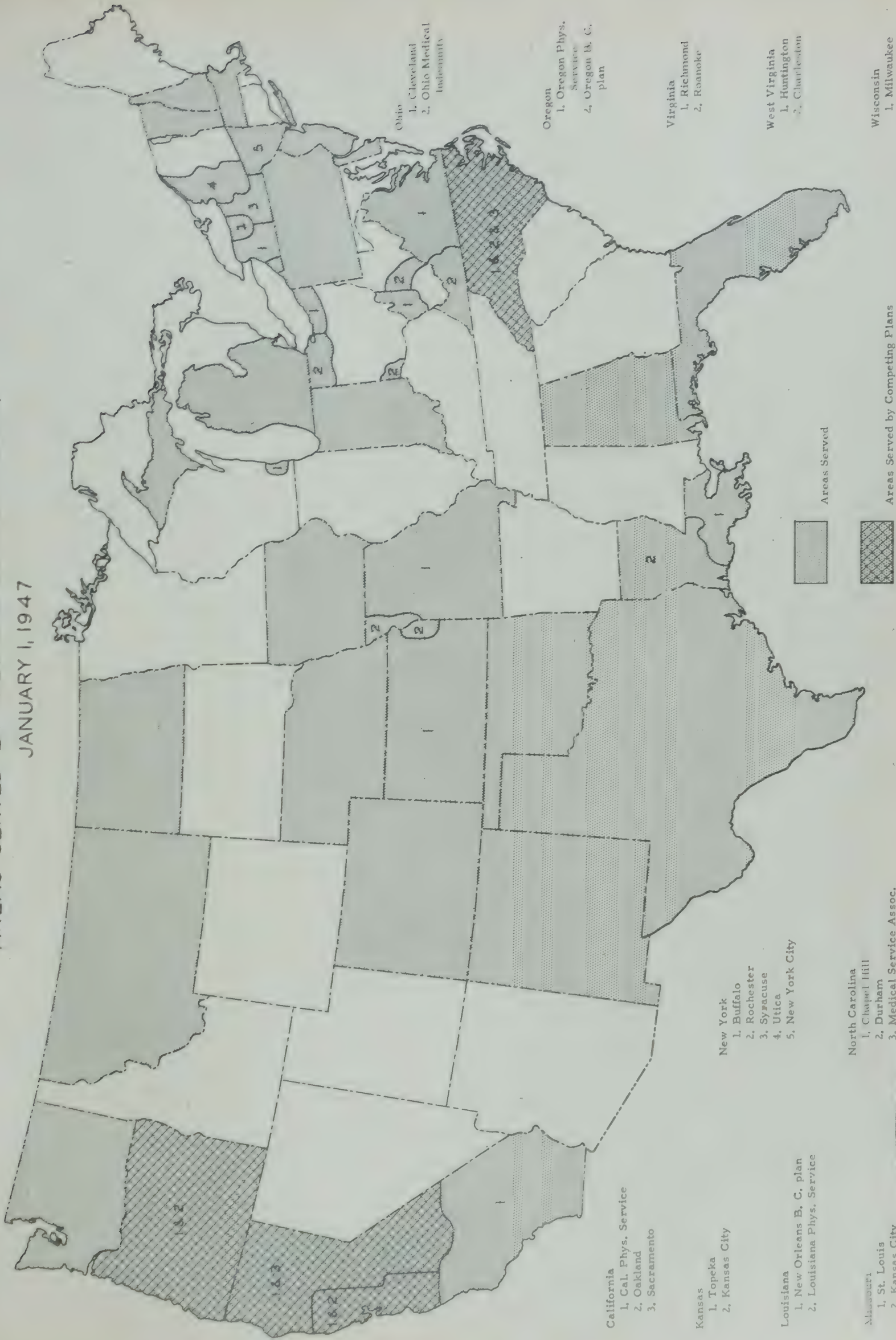
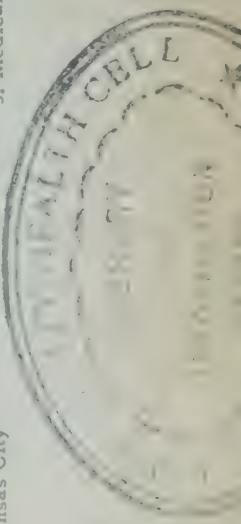


FIGURE 13



between the two plans usually on the basis of their relative gross incomes.

The next most common relationship is that in which the two plans are separate corporations with separate boards and different executive directors, but there is some administrative coordination between them. Generally the hospital plan performs enrollment and billing for the medical plan, or there is joint control of these functions. In some cases the staff of the hospital plan also handles the payment of medical claims, or again there is joint control over this function. This relationship exists between 9 medical plans and 14 hospital plans, ^{3/} and possibly in the case of two other pairs of plans for which definite information is not at hand. It is found in a number of instances in which the medical plan is on a state-wide basis but cooperates with two or more hospital plans serving local areas, as in Iowa, Louisiana, and Ohio.

In nine cases the medical and hospital plans are one and the same. ^{4/} All of these plans began as hospital plans and subsequently expanded to provide medical coverage. All of these medical plans issue indemnity contracts and with some exceptions, of which Delaware is one, they do not have the strong support of the medical profession of the area. Four of them (Oakland, Sacramento, New Orleans and Oregon) serve areas in which the medical profession has its own plan.

In three States and part of another there is no cooperation between the medical plans sponsored by the medical profession and the hospital plans. In Washington active competition exists between the county medical bureaus, which include hospitalization in their contracts, and the State-wide Blue Cross plan. However, two bureaus, those of Yakima and Clark (Vancouver) Counties have dropped hospitalization from their contracts and have entered into cooperative relationships, the one with the Washington Blue Cross plan and the other with the Oregon Blue Cross plan. In Oregon, sharp competition exists between Oregon Physicians' Service and its affiliated county bureaus, which include hospitalization in their contracts, and the Oregon Blue Cross plan which since 1946 has offered medical coverage. In California, there is very close administrative cooperation between California Physicians' Service and the Los Angeles Blue Cross plan -- indeed the two plans really function as a single administrative unit. However, in the northern part of the State there is competition between CPS and the two Blue Cross plans. In Pennsylvania, the state-wide medical plan and the five local Blue Cross plans have not been able to agree upon a suitable basis of cooperation, although it is understood that efforts in this direction are being made.

In a number of States cooperative relationships between the medical and hospital plans are impeded or will be impeded because of differences in the areas served. In California, Louisiana, Iowa, Ohio and Pennsylvania the plan sponsored by the medical profession is or intends to be on a state-wide basis, but there are two or more hospital plans serving these States. In Virginia the plan which serves the eastern part of the State must cooperate with four separate hospital plans. ^{5/} Obviously close cooperation or administrative

^{3/} Between the medical and hospital plans in Southern California, Michigan, Montana, New Jersey, Cleveland, and between (a) Louisiana Physicians' Service and the Alexandria and Baton Rouge Blue Cross plans, (b) Ohio Medical Indemnity and the Cincinnati and Toledo plans, (c) Iowa Medical Service and the two Iowa hospital plans, and (d) Virginia Medical Service and the Lynchburg, Newport News and Norfolk plans. This relationship may also exist between the New Mexico hospital and medical plans and the Utah hospital and medical plans -- definite information on this point is not at hand.

^{4/} Alabama, Oakland, Sacramento, Delaware, New Orleans, Chapel Hill, Hospital Care Ass'n. of Durham, Northwest Hospital Service of Oregon, Huntington.

^{5/} Virginia Medical Service, operated by the Richmond Blue Cross plan.

unification in these areas is difficult or impossible unless either the medical plan breaks down into two or more local plans, or the local hospital plans consolidate into a state-wide plan.

POPULATION ENROLLED

As of January 1, 1947 the medical plans had a total enrollment of 4,436,000. A considerable part of this enrollment, almost half, is in four plans -- Michigan, Massachusetts, California Physicians' Service and New York City.

In the case of some medical plans enrollment is rapidly catching up with enrollment in the allied hospital plan. Thus in 8 plans, over 50 percent of the members of the hospital plan have been enrolled for medical benefits. In southern California, well over 80 percent of the members of the hospital plan are enrolled with the medical plan. In Delaware 77 percent of those with hospital coverage also have medical coverage. In Michigan the proportion is 73 percent, in Kansas City 62 percent. A number of allied or integrated hospital and medical plans now offer the combined coverage at a single price, and prospective subscribers customarily take both coverages or neither.

Table 22 shows the enrollment in medical plans by States, the percentage of the population enrolled, and net growth during 1946. In Delaware 36 percent of the population of the State have been enrolled, in New Hampshire 19 percent, ^{6/} in Colorado 16 percent, in Michigan 16 percent. In 6 other States between 5 and 13 percent of the State population are members. During 1946, two plans, Delaware and New Hampshire, had a net growth in enrollment of more than 10 percent of the State's population, and two others, Colorado and Massachusetts had a net growth of between 5 and 10 percent. The Michigan plan had a decrease in enrollment owing largely to administrative difficulties of the hospital plan which conducts enrollment for it. ^{7/}

NOTE ON RECENT CHANGES

Since January 1, 1947 and up to June 1, the following changes have occurred:

The plan with headquarters in Milwaukee, Wisconsin has been extended to serve the entire State. Ohio Medical Indemnity has entered into cooperative relationships with all or virtually all of the Blue Cross plans in the State, excepting the Cleveland plan, so that it serves all or most of Ohio outside of the Cleveland area. A plan with headquarters in Albany, N. Y., and affiliated with the Albany Blue Cross plan, has begun enrollment.

The medical plans affiliated with Blue Cross plans reported a total enrollment as of April 1, 1947 of 4,565,138 (this is exclusive of the plans outside the United States, and of the Yakima plan in Washington). Addition of the total (approximate) enrollment in Oregon, Pennsylvania and Washington as of the first of the year, brings the total enrollment to 4,957,000.

^{6/} The New Hampshire medical plan was expanded to include Vermont only in November 1946. Hence virtually all of its enrollment as of January 1, 1947 was in New Hampshire.

^{7/} Appendix I shows the enrollment history of each plan since its establishment.

TABLE 22

Enrollment in Medical Plans by States, Jan. 1, 1947
Percent of the Total Population Enrolled and 1946 Growth

STATE	ESTIMATED CIVILIAN POPULATION JULY 1, 1945	ENROLLMENT JAN. 1, 1947	PERCENT OF POPULATION ENROLLED	1946 GROWTH	PERCENT OF POPULATION ENROLLED IN 1946
DELAWARE	277,455	100,983	36.4	31,465	11.3
NEW HAMPSHIRE ^{1/}	445,930	85,370	19.1	48,507	10.9
COLORADO	1,060,239	174,132	16.4	78,770	7.4
MICHIGAN	5,435,092	850,000	15.6	-8,235	2/
WASHINGTON	1,953,725	250,000 ^{3/}	12.8	50,000 ^{3/}	2.6 ^{3/}
MASSACHUSETTS	4,086,197	461,000	11.3	239,155	5.9
NORTH CAROLINA	3,333,999	318,504	9.6	112,875	3.4
OREGON	1,193,702	96,741 ^{3/}	8.1	11,741 ^{3/}	1.0 ^{3/}
CALIFORNIA	8,120,105	573,546	7.1	328,551	4.0
MISSOURI	3,481,949	181,849	5.2	109,854	3.2
NEW YORK	12,343,450	598,474	4.8	328,993	2.7
VIRGINIA	2,810,278	105,059	3.7	73,009	2.6
INDIANA	3,387,463	82,531	2.4	82,531	2.4
WISCONSIN	2,934,044	66,900	2.3	66,900	2.3
NEW JERSEY	4,104,176	88,088	2.1	38,647	0.9
MONTANA	452,519	8,996	2.0	8,996	2.0
NEBRASKA	1,155,744	21,540	1.9	15,961	1.4
WEST VIRGINIA	1,716,944	31,442	1.8	10,608	0.6
OHIO	6,823,137	118,324	1.7	99,957	1.5
ALABAMA	2,728,120	45,791	1.7	38,773	1.4
NORTH DAKOTA	519,709	6,185	1.2	6,185	1.2
OKLAHOMA	1,941,499	20,283	1.0	17,672	0.9
LOUISIANA	2,343,406	21,384	0.9	16,157	0.7
KANSAS	1,656,588	14,558	0.9	14,558	0.9
IOWA	2,236,203	17,214	0.8	14,069	0.6
UTAH	591,910	4,044	0.7	4,044	0.7
PENNSYLVANIA	9,142,797	55,000 ^{3/}	0.6	34,000 ^{3/}	0.4 ^{3/}
NEW MEXICO	490,302	2,583	0.5	2,583	0.5
TEXAS	6,338,309	32,242	0.5	21,388	0.3
FLORIDA	2,059,505	2,919	0.1	2,919	0.1
OTHER STATES	32,244,801	0	0	0	0
TOTAL U.S.A.	127,409,297	4,435,682	3.48	1,908,868	1.5

^{1/} The New Hampshire medical plan was expanded to include Vermont in November 1946. Hence, almost all enrollment as of the end of the year was in New Hampshire.

^{2/} Decrease

^{3/} Approximate

CHAPTER 16

SUBSCRIPTION RATES AND BENEFITS

Table 23 shows the rates charged and the scope of benefits provided by the various medical plans.

In general the contracts offered by the medical plans -- some plans offer more than one type of contract -- fall into the following three main groups:

1. Contracts covering surgical and obstetrical service, with or without coverage of x-ray, anesthesia and laboratory services.
2. Contracts covering these same services, and in addition hospital calls in medical cases. This coverage may be offered in a single inclusive contract or through a contract of type 1 supplemented by a separate contract covering hospital calls.
3. Contracts providing surgery, obstetrics and office, home and hospital calls. This expanded coverage may be offered through a contract of type 1 supplemented by a contract offering office, home and hospital calls or through a single contract.

SURGICAL CONTRACTS

A little more than one third of the plans offer only the first type of contract. These limited contracts are usually known as surgical contracts; actually, however, both surgery and obstetrics are covered. The contracts offered by some plans cover only surgery performed in the hospital; other plans cover surgery performed in both the hospital or office, and still other plans -- more numerous than either of the other two groups -- cover all surgery irrespective of where it is performed. Actually these distinctions are not very important, since almost all surgical procedures of any complexity are performed in the hospital in any case. Some contracts cover only obstetrical service performed in a hospital; others do not have this restriction. Again the distinction is unimportant since the medical coverage is only sold to persons enrolled in the hospital plan, and a woman who has hospital coverage will certainly go to the hospital for her confinement.

The coverage of x-ray, anesthesia and laboratory services under the surgical contract is determined very largely by the scope of the allied hospital plan. In general, the surgical plan will offer such of these services as are not offered under the hospital plan. In most instances, when these services are offered, they are available only to hospitalized patients or are offered only in connection with surgical cases covered by the plan.

About two thirds of the medical plans provide x-ray service. Very few of these provide the service without limit, most furnish the service up to a dollar limit -- commonly \$15.00 - per contract year or per admission. Limitations of the same sort are also imposed, though less frequently, upon anesthesia and laboratory service. A number of the plans provide electrocardiograph and basal metabolism tests.

TABLE 23
SUBSCRIPTION RATES CHARGED AND BENEFITS PROVIDED

LEGEND: "X" Means Benefit is Provided

PLAN	MONTHLY SUBSCRIPTION RATES			SURGICAL BENEFITS (including orthopedics)			OBSTET- RICAL	SPECIAL BENEFITS (see code)						MEDICAL BENEFITS (for non-surgical and non-obstetrical cases)				LIMITATIONS ON TOTAL LIABILITY
	SINGLE PERSONS	HUSBAND AND WIFE	FAMILY	HOS- PITAL	OFFICE	HOME	BENE- FITS	X-RAY	ANES- THESIA	LABO- RATORY	OTHER	LIMITATIONS ON SPECIAL BENEFITS	HOS- PITAL	OFFICE	HOME	LIMITATIONS ON MEDICAL BENEFITS		
ALABAMA	.75	1.50	2.00		X	X	X	X	\$150	\$150	\$100	1,2,3,4,12	H	X			25 VISITS PER YEAR.	\$200 A YEAR FOR SURGERY
CAL PHYS. SERV. I	2/	2.90	3.90		X	X	X	X	X	X	X	1,2,4,5,6,12	2/	X	X	X	TWO VISIT DEDUCTIONS, EACH DEDUCTION BENEFIT AVAILABLE TO EMPLOYED SUBSCRIBERS ONLY.	THREE MONTHS' SERVICE IN CHRONIC CONDITIONS.
OAKLAND, CAL.	8/	2.00	3.00		X	X	X	X	X	X	X	5,6	3, H					FOR SURGERY \$225 PER DISABILITY
SACRAMENTO, CAL.	1/	1.50	2.40		X	X	X	X	X	X	X							\$150 PER DISABILITY
CIA GRADO	2/	1.50	2.00		X	X	X	X	\$150	\$150	\$100	1,2,5		X				\$150 PER DISABILITY
DELAWARE	.60		1.65		X	X	X	X	\$150	\$150	\$100			X				\$150 PER DISABILITY
FLORIDA	.40		2.00		X	X	X	X	\$150	\$150	\$100			X				\$150 PER DISABILITY
INDIANA I	.75		2.00		X	X	X	X										\$150 PER DISABILITY WITHIN ANY ONE 5 MONTHS' PERIOD
INDIANA II	1.00		2.25		X	X	X	X	\$150	\$150	\$100			X				
IOWA I	1.25		2.50		X	X	X	X	\$150	\$150	\$100			X				FOR 21 DAYS AFTER 3RD DAY
IOWA II					X	X	X	X						X				FOR 21 DAYS AFTER 3RD DAY
KANSAS	.90		2.25		X	X	X	X	\$150	X				X				FOR 30 DAYS PER YEAR AFTER 3RD DAY
LOUISIANA PHY. SERV.	.85	1.85	2.10		X	X	X	X	\$150	\$150	\$50							
NEW ORLEANS, LA.	.75	1.50	2.00		X	X	X	X										\$150 A YEAR PER DISABILITY, \$250 A YEAR PER INDIVIDUAL.
MASSACHUSETTS	.85	1.65	2.00		X	X	X	X	\$150	X		5,6		X				\$150 PER DISABILITY
MICHIGAN I	.60	1.60	2.25		X	X	X	X	\$150	X				X				\$150 A YEAR FOR RELATED SURGERY
MICHIGAN II	.90	2.20	3.25		X	X	X	X	\$150	X				X				
KANSAS CITY, MO. I	.75	1.50	2.00		X	X	X	X	\$150	X		4, 1,2,3,13		X				\$150 PER DISABILITY, \$250 PER PERSON, \$500 FOR HUSBAND AND WIFE, AND \$250 PER FAMILY. MEDICAL BILLS SAME LIMITATIONS AS ST. LOUIS.
KANSAS CITY, MO. II	1.10	.50	.25		X	X	X	X						X				
ST. LOUIS, MO.	.85	1.85	2.25		X	X	X	X	\$250	X	X	1,2,3		X				\$150 PER DISABILITY, \$250 PER PERSON, \$500 FOR HUSBAND AND WIFE, \$1,000 PER FAMILY.
MONTANA	1.50	2.50	3.90		X	X	X	X	X	X	X	4,5,6		X				\$250 A YEAR PER PERSON
NEBRASKA	1.00	2.00	2.50		X	X	X	X	\$250	X		1,4		X				FOR SURGERY, \$150 PER DISABILITY
NEW HAMPSHIRE I	.75	1.50	1.75		X	X	X	X	\$250	\$100	\$150	6		X				\$250 A YEAR PER PERSON
NEW HAMPSHIRE II	.85	1.50	1.50		X	X	X	X	\$250	\$100	\$150	6		X				FOR SURGERY, \$150 PER DISABILITY
NEW JERSEY	.75		2.00		X	X	X	X		X		5		X				
NEW MEXICO	1.25	2.25	3.90		X	X	X	X	\$150	X				X				FOR SURGERY, \$150 PER DISABILITY
BUFFALO, N. Y.	.60		1.70		X	X	X	X	\$150	\$100				X				FOR SURGERY, \$150 PER DISABILITY
NEW YORK, N. Y. I	.40	1.00	1.40		X	X	X	X						X				\$150 FOR OPERATIONS FOR SAME ILL-NESS OR CONDITION 2/
NEW YORK, N. Y. II	.60	1.50	2.95		X	X	X	X	X	X	X			X				
NEW YORK, N. Y. III	1.60	4.00	4.00		X	X	X	X	X	X	X	1,2,3,4,5,12		X				\$150 FOR OPERATIONS IN ANY 3 MONTHS' PERIOD.
ROCHESTER, N. Y.	.60		1.70		X	X	X	X	\$150	\$100				X				FOR SURGERY, \$150 PER DISABILITY
SYRACUSE, N. Y. I	.60		1.70		X	X	X	X	\$150	\$100				X				
SYRACUSE, N. Y. II	.90		1.70		X	X	X	X	\$150	\$100				X				

The rates charged for the surgical contract tend to be about the same or somewhat less than those charged by the hospital plans for hospital coverage. Some examples are: the Colorado plan -- \$.75 a month for a single person, \$1.50 for husband and wife, and \$2.00 for a family; the Delaware plan -- \$.60 for a single person and \$1.65 for a husband and wife or a family; the New York City plan -- \$.40, \$1.00 and \$1.80 for a single person, husband and wife, and a family respectively. The lowest rates for this type of contract are those of the two North Carolina plans, both of which issue, at a family rate of \$.90 a month, contracts with a low schedule of allowances, \$75 being the maximum paid for any operation. (Both plans also offer contracts carrying a higher schedule of allowances.) The highest rate charged for this type of contract is that of California Physicians' Service. This plan charges \$.80 a month for a single male, \$1.20 for a single female, \$2.00 for a husband and wife, and \$3.00 for a family, and the contract does not provide obstetrical service. The plan has a high fee schedule, and unlike most other plans, provide a fee for the services of an assistant at an operation.

CONTRACTS COVERING SURGERY, OBSTETRICS AND HOSPITAL CALLS

A growing number of plans (at present 22 out of 44) cover surgery, obstetrics and physicians' services in hospitalized medical cases. Most plans offer this coverage in a single contract. A few -- usually those which previously offered only a surgical contract -- offer a hospital call contract as an optional supplementary contract to the surgical contract. A number of plans offer both the surgical contract and the surgical and hospital call contract, and the subscriber takes his choice. The general tendency is for the plan to push the sale of the more comprehensive contract and in time the less comprehensive contract is dropped.

Under most of the plans hospital calls are covered only after a waiting period, usually three days, i.e., coverage begins with, say, the fourth day of hospitalization. However, a few of the plans provide coverage from the first day of hospitalization, and a few others provide coverage from the first day in cases staying in the hospital four days or more. The reason for the waiting period, of course, is to prevent any tendency for people to request hospitalization in minor illnesses solely so that the plan would pay the physician's bill.

All or virtually all of the plans offering this type of coverage place strict limits on the number of hospital calls for which the plan will pay.^{1/} Thus, the Charleston plan will pay for no more than one visit per day for not more than 42 days per year. The two Missouri plans cover physicians' visits for 21 days in stays of 4 or more days. The New York City plan pays physicians' charges to the extent of \$3.00 for each day of hospitalization from the 4th till the 21st day, and thereafter up to \$10 a week, up to the 111th day of hospitalization. The Utica plan will pay for 21 calls per hospital stay. The same plan, probably to guard against the possibility that patients might stay in the hospital solely to obtain payment of the physician's bill, will also pay for up to 3 home or office calls within 10 days of discharge from the hospital.

Monthly subscription charges for the surgical, obstetrical and hospital call contract tend to run \$.25 to \$.75 (for a family) more than those for the

^{1/} Where the subscriber is entitled to indemnity benefits, coverage of hospital calls may be provided by allowing either a certain payment for each call or a given amount for each day in the hospital.

surgical contract, in plans which offer both types of contracts. Typical charges are: The Massachusetts plan, \$.85 for a single person, \$1.65 for husband and wife and \$2.00 for a family;^{2/} Michigan, \$.90, \$2.20, \$3.25; St. Louis, \$.85, \$1.85 and \$2.25. The Kansas City plan charges a family rate of \$.25 a month for its separate hospital call contract sold as a supplementary contract to the surgical contract.

CONTRACTS PROVIDING SURGERY, OBSTETRICS AND OFFICE, HOME AND HOSPITAL CALLS

Seven plans offer this coverage. However, one of these plans (Medical Service Association of Durham, N. C.) is restricted to Farm Security Administration borrowers, and another offers this coverage only on an experimental basis.

The New Hampshire-Vermont and the Syracuse plans offer a so-called medical contract covering physicians' office, home and hospital calls, as an optional, supplementary contract to the surgical one.^{3/} The first plan charges \$.65 a month for a single person, \$1.30 for husband and wife and \$1.50 for a family for its contract. It is on a two-visit deductible basis, i. e., the subscriber pays for the first two visits in any illness, and has a limit of 30 calls a year per person. As of January 1, 1947 about 20 percent of the subscribers in the plan had enrolled for this contract. The Syracuse plan charges \$.90 a month for a single person and \$1.30 for husband and wife or a family. There is a limit of 25 calls per year for the subscriber and 15 for each dependent.

California Physicians' Service provides its medical coverage only to the employed person. The charge is \$.90 a month over and above the charge for the surgical contract. Care is furnished up to a year for each non-chronic illness but the subscriber must pay for the first two calls in each separate illness or accident. CPS furnishes obstetrical care under this contract rather than under the surgical contract as do the other plans.

The plans in Washington and Oregon offer a comprehensive service, except for obstetrics, to the employed person and some of these plans have recently extended partial or comprehensive coverage to dependents. The King County (Seattle) Medical Service Bureau, the largest plan in Washington, charges \$1.75 a month to the employed person for its so-called Standard Contract.^{4/} This provides physicians' care and hospitalization for 26 weeks in any one illness. Care is not provided for childbirth, pre-existing conditions, conditions not common to both sexes, venereal disease, chronic ailments and various other conditions. A contract which provides physicians' care for eight months and hospitalization for six months in any one illness and which covers practically all conditions, except obstetrical, is offered for \$2.75 a month. Oregon Physicians' Service charges \$3.00 a month and offers physicians' services for one year and hospitalization for six months for any illness. An annual health examination is included. Special nursing, extractions, and ambulance service are also provided. Obstetrical and a number of other condi-

^{2/} These were formerly the rates for the surgical contract. The plan added hospital calls without increasing the subscription cost.

^{3/} The Buffalo plan used to offer a contract of this type but was forced to discontinue its sale because of unfavorable experience.

^{4/} Data as of February 1945. Later data not available.

tions are not covered. This contract is available only to employed persons. Recently contracts providing hospitalization and surgical service for dependents have been offered.

Some of the county plans in Washington have begun to offer to dependents the comprehensive service that was formerly offered only to employed persons. The charge for the employed person and his dependents is said to range from \$5.00 to \$10.00 a month.

The New York City plan has offered on an experimental basis a contract providing quite comprehensive coverage of physicians' services, i. e., surgery, obstetrics and hospital, office and home visits. Calls in excess of 20 for any one illness are subject to specific authorization of the plan. The charge is \$1.60 a month for a single person and \$4.00 a month for husband and wife or a family. Enrollment has been held to about 15,000 persons.

MATERNITY BENEFITS; CONDITIONS EXCLUDED FROM COVERAGE

Table 24 shows the provisions of the plans with respect to maternity benefits and certain conditions which are not covered or are covered only after a waiting period. In all instances the plans provide care for maternity only after the woman has been enrolled for a certain period -- usually 9 or 10 months. Most plans also require that a woman to be eligible for maternity care must be enrolled under either a husband and wife or a family contract. The provisions of a medical plan with respect to maternity benefits are virtually always the same as those of the hospital plan with which it is allied.

A little less than half (19 out of 44) of the plans exclude care for pre-existing conditions, and an additional 11 provide service for such conditions only after the member has been enrolled for a certain period -- usually six months or a year. As with hospital prepayment some of the plans waive this exclusion in the case of large groups with a high percentage of enrollment. Some 29 of the plans will provide a tonsil operation only after the member has been enrolled for a certain period -- 3 months to a year; 11 plans have a waiting period for hernia operations and a few (8) for hemorrhoid operations. The rationale of these restrictions, of course, is to prevent abuse of the plan by persons who learn that they need an operation and then enroll in the plan.

Of the 44 plans 22 exclude plastic surgery for cosmetic reasons, 14 exclude service for tuberculosis after diagnosis, the same number do not provide care for mental disorders and 13 exclude care for venereal disease. A number of the plans have one or two or more other exclusions. Common ones are service in drug addiction or alcoholism cases, self-inflicted injuries and congenital conditions.

SERVICE AND INDEMNITY BENEFITS

The plans fall into three main groups: those on a straight service basis; those on a service-indemnity basis; and those on a straight indemnity basis.^{5/}

^{5/} Again it is emphasized that the distinction between "service" and "indemnity" does not lie in whether the plan pays the doctor or the patient. Most of the indemnity plans pay the physician directly. The distinction lies in whether or not the physician agrees to accept the plan's payment as full remuneration for his services and to make no extra charge to the patient. Possibly the term "indemnity" is not fully descriptive. In some respects the term "dollar allowance" might be better. But indemnity will be used because it is the one in current usage.

TABLE 24

Maternity Benefits and Conditions Excluded (Data as of December 1946)

PLAN	MATERNITY BENEFITS ARE PROVIDED		"X" OR CODE LETTER INDICATES EXCLUSION NUMBER INDICATES WAITING PERIOD IN MONTHS							CONDITIONS EXCLUDED INDICATES WAITING PERIOD IN MONTHS			
	UNDER SPECIFIED TYPE OF CONTRACT A - SINGLE B - HUSBAND AND WIFE C - FAMILY	AFTER THE FOLLOWING WAITING PERIOD (in months)	PRE- EXIST- ING CONDI- TIONS	TONSILS AND ADENOIDS	HERNIA	PLASTIC SURGERY FOR COSMETIC PURPOSES	TUBERCU- LOSIS AFTER DIAGNOSIS	MENTAL DISEASES	VENEREAL DISEASES	OTHER (See Code)			
ALABAMA	C	12	x	3	-	x	-	-	x	d, f			
CALIFORNIA PHYSICIANS' SERVICE	A	10	-	-	-	-	-	-	-	-			
OAKLAND, CALIFORNIA	A, B, C	10	x	-	-	-	-	x	-	c, k			
SACRAMENTO, CALIFORNIA	B 1/, C 1/ B, C	10	x	-	-	-	x	-	-	-			
COLORADO	C	12	2/ 12	-	-	x	-	-	-	n			
DELAWARE	C	10	x	12	12	x	-	-	x	a, b			
FLORIDA	C	10	10	3	-	x	-	-	-	-			
INDIANA	C	10	10	6	-	x	-	-	-	-			
IOWA	C	9	-	9	-	x	-	-	-	-			
KANSAS	C	8	8	8	-	x	x	x	-	g			
LOUISIANA PHYSICIANS SERVICE	C	10	12	3	3	x	-	-	-	b, q			
NEW ORLEANS	C	10	x	12	12	x	-	-	-	h, n			
MASSACHUSETTS	B, C	9	-	-	-	-	-	-	-	-			
MICHIGAN	A, B, C	9	-	-	-	-	-	-	-	-			
KANSAS CITY, MISSOURI	C	10	x	6	-	x	-	-	-	a, b, d, h			
ST. LOUIS, MISSOURI	C	10	x	10	-	x	-	-	-	-			
MONTANA	B, C	9	-	-	-	-	-	-	-	-			
NEBRASKA	C	12	x	6	6	-	-	-	-	a, b, c, d, h, j			
NEW HAMPSHIRE - VERMONT	C	12	12	12	12	-	-	x	x	a, n			
NEW JERSEY	C	9	-	9	-	-	-	-	-	-			
NEW MEXICO	B, C	10	-	6	6	-	x	-	-	p			
BUFFALO, NEW YORK	C	12	x	10	10	-	-	-	-	a, h, o			
NEW YORK, NEW YORK	C	10	11	6	-	x	-	-	-	a, c, d, 3/			
ROCHESTER, NEW YORK	C	10	12	12	12	-	x	-	-	a, h, n, r			
SYRACUSE, NEW YORK	C	12	12	10	10	-	-	-	-	a, h, o			
UTICA, NEW YORK	B, C	10	x	6	6	-	-	-	-	-			
CHAPEL HILL, NORTH CAROLINA	C	10	x	-	-	-	x	-	x	-			
HOSPITAL CARE ASS'N., DURHAM, N. C.	B, C	10	x	10	-	-	x	-	x	a, b			
MEDICAL SERV. ASS'N., DURHAM, N.C. 4/	C	0	-	x	-	-	-	-	-	-			
NORTH DAKOTA	C	10	x	6	-	-	x	-	-	-			
CLEVELAND, OHIO	C	12	-	-	-	-	-	-	-	-			
OHIO MEDICAL INDEMNITY	C	9	-	6	-	-	-	-	-	-			
OKLAHOMA	A, B, C	10	x	-	-	-	-	-	-	a, b, c, e			
OREGON PHYSICIANS' SERVICE 5/	B, C	10	x	12	-	-	x	x	x	a, b, c, d			
NORTHWEST HOSPITAL SERVICE, OREGON	B, C	10	x	-	-	-	x	x	x	a, d 6/			
PENNSYLVANIA	B 1/, C	12	-	8/ 5	-	-	-	-	-	-			
TEXAS 2/	C	12	x	10	-	-	-	-	-	-			
UTAH	C	10	12	12	12	-	-	-	-	d			
RICHMOND, VIRGINIA	C	10	12	6	-	-	-	-	-	i			
ROANOKE, VIRGINIA	C	9	12	6	-	-	-	-	-	-			

TABLE 24

Maternity Benefits and Conditions Excluded
(Data as of December 1946)

PLAN	MATERNITY BENEFITS ARE PROVIDED		"X" OR CODE LETTER INDICATES EXCLUSION NUMBER INDICATES WAITING PERIOD IN MONTHS							
	UNDER SPECIFIED TYPE OF CONTRACT A - SINGLE B - HUSBAND AND WIFE C - FAMILY	AFTER THE FOLLOWING WAITING PERIOD (in months)	PRE- EXIST- ING CONDI- TIONS	TONSILS AND ADENOIDS	HERNIA	PLASTIC SURGERY FOR COSMETIC PURPOSES	TUBERCU- LOSIS AFTER DIAGNOSIS	MENTAL DISEASES	VENEREAL DISEASES	OTHER (see code)
WASHINGTON (KING COUNTY) 10/ CHARLESTON, WEST VIRGINIA HUNTINGTON, WEST VIRGINIA MILWAUKEE, WISCONSIN	11/ A, B, C C C	11/ 10 10 9	12/ 6 - -	- 6 - -	- - - -	- - - -	x x x -	x x x -	x x x -	a, b a, b, c, m a, b, c -

FOOTNOTES

- 1/ Maternity benefits are covered only in large groups with at least a 75 percent enrollment.
- 2/ Services are not available for conditions for which a person is in a hospital or ill at home on the effective date (first day) of the contract.
- 3/ All exclusions specified in the various contracts offered by plan are listed herein.
- 4/ For Farm Security Administration borrowers.
- 5/ Provisions of single contract for employed subscribers are not shown. They do not include maternity benefits; there is no waiting period for tonsillectomies; and the specific exclusions vary from those shown in the table.

- 6/ There are a few other relatively unimportant conditions excluded under the plan's hospital contract.
- 7/ Under medical-surgical plan. Under surgical plan, maternity benefits are provided only in family contracts.
- 8/ Under medical-surgical plan. Under surgical plan, there is a six-months waiting period for dependents.
- 9/ Data as of March 1946.
- 10/ Data as of March 1945.
- 11/ Maternity care not provided.
- 12/ Under lower cost contract, pre-existing conditions and diseases not common to both sexes are excluded.

CODE FOR CONDITIONS EXCLUDED

- a Drug addiction and alcoholism
- b Self-inflicted injuries
- c Contagious diseases
- d Congenital conditions
- e Arthritis
- f Tuberculosis except for thoracoplasty
- g Diabetes
- h Plan does not provide service to individuals who have ever had cancer, diabetes, osteomyelitis, tuberculosis, or (except Nebraska) chronic nephritis or coronary thrombosis.
- i Waiting period (12 months) for tuberculosis and nervous and mental conditions.
- j Waiting period (6 months) for chronic appendicitis, hemorrhoids, gall-bladder, ulcers, and certain gynecological and urological conditions.
- k Waiting period (12 months) for diseases - not common to both sexes.
- m Waiting period (6 months) for diseases peculiar to women.
- n Waiting period (12 months) for hemorrhoids
- o Waiting period (10 months) for hemorrhoids
- p Waiting period (6 months) for hemorrhoids
- q Waiting period (3 months) for hemorrhoids
- r Waiting period (12 months) for menopausal conditions

The plans in Washington and Oregon, and the North Dakota and Roanoke plans, constitute the first group. The full service character of the Washington and Oregon plans requires qualification in the light of the fact that some of them do not enroll all population groups irrespective of income. Some of the county medical society plans in Washington have an income limit for subscribers -- they usually endeavor to limit enrollment to those with incomes under \$2500; others have no such income limit. Oregon Physicians' Service has no formal income limit (some of its affiliated county plans do) but endeavors to avoid enrollment of persons with high incomes.

Of the 44 plans, 17, including most of those with large enrollment, offer service benefits to some of their subscribers, depending upon income or hospital accommodations used, or both, and indemnity benefits to others.^{6/} The remaining 23 plans offer indemnity benefits only.^{7/}

Under the service-indemnity plans, as Table 25 shows, the income limits for service benefits are generally \$1500, \$1800 or \$2,000 for a single person and \$2500 or \$3,000 for husband and wife or a family. The Montana and New Mexico plans have the highest limits -- \$4,000 for a single person or a family. Colorado has the lowest limits -- \$1500 for a single person, \$1920 for a couple and \$2400 for a family.

Two plans, New Jersey and Michigan, stipulate that a subscriber to be entitled to service benefits must not only have an income under the specified level but must occupy a ward or semi-private room at the hospital. If he occupies a private room, when use of such a room is not required by the nature of the illness, the physician can charge him extra. One plan, Utah, has no income limits for service benefits. If the subscriber takes ward or semi-private hospital accommodations he is entitled to service benefits; if he takes a private room, unless this is required by the nature of his illness, the physician can make an extra charge.

The full service plans provide their subscribers with a contract which states that they are entitled to certain services as needed. The indemnity plans provide their subscribers with a contract which contains a schedule of indemnity allowances for each operation or service. The service-indemnity plans pursue different policies in this regard. The contracts of a few plans -- Kansas, Kansas City, New York City and Richmond -- contain a schedule of dollar allowances and a statement that participating physicians have agreed

^{6/} The New York City plan has been included among the plans on a service-indemnity basis. There may be some question as to this classification. This plan has been issuing both indemnity and service-indemnity contracts. Recently the plan has raised the allowances paid under the indemnity contracts to the same amounts (except for delivery) as those paid under the service-indemnity contracts. Since participating physicians agree to accept these amounts as full payment for subscribers under the designated income limits, the contracts that were formerly on an indemnity basis have for all practical purposes been put on a service-indemnity basis.

^{7/} There appears to be a trend towards the service-indemnity type of plan and away from the straight indemnity type. Thus of the 10 plans started in 1945, one was on a service, 2 were on a service-indemnity, and 7 on an indemnity basis. Of the 12 plans started in 1946, one was on a service, 7 were on a service-indemnity, and 4 on an indemnity basis.

TABLE 25

Income Limits and Other Requirements for Service Benefits Under Service-Indemnity Plans

Data as of December 1946

PLAN	INCOME LIMITS			OTHER REQUIREMENTS
	SINGLE PERSON	HUSBAND AND WIFE	FAMILY	
	\$	\$	\$	
CALIFORNIA PHYSICIANS' SERVICE	3,000	3,000	3,000	-
COLORADO	1,500	1,920	2,400	-
FLORIDA	2,000	3,000	3,000	-
IOWA	1,500	2,500	2,500	-
KANSAS	1,800	2,400	2,400	-
LOUISIANA PHYSICIANS SERVICE	2,000	3,000	3,000	-
MASSACHUSETTS	2,000	2,500	2,500 ^{a/}	-
MICHIGAN	2,000	2,500	2,500	WARD OR SEMI-PRIVATE ACCOM- (MODATIONS)
KANSAS CITY, MO.	1,800	2,400	^{b/}	-
MONTANA	4,000	4,000	4,000	-
NEW JERSEY	2,000	2,500	^{c/}	WARD OR SEMI-PRIVATE ACCOM- (MODATIONS)
NEW MEXICO	4,000	4,000	4,000	-
NEW YORK, N. Y.	1,800	2,500	2,500 ^{d/}	-
PENNSYLVANIA	1,560	2,340	3,120	-
UTAH	-	-	-	WARD OR SEMI-PRIVATE ACCOM- (MODATIONS)
RICHMOND, VA.	2,000	2,500	3,000	-
MILWAUKEE, WISC.	2,000	3,600	3,600	-

^{a/} This was raised early in 1947 to \$3,000.

^{b/} Husband, wife and one child, \$2,600; two children, \$2,800; three or more children, \$3,000.

^{c/} Husband and wife, \$2,500; \$250 additional for each child.

^{d/} A family subscriber with income between \$2,500 and \$3,500 may ask for review of the reasonableness of any extra charge by a special committee of physicians.

to accept the stated allowances as full payment in the case of subscribers under the specified income limits. The remaining plans provide their subscribers with a contract which states that subscribers with incomes under certain levels, etc., are entitled to specified medical services, but that participating physicians may make an extra charge to subscribers not entitled to service benefits.

These latter plans, it is apparent, do not make plain to the subscribers not entitled to service benefits (and these subscribers often constitute more than 50 percent of the total) just what benefits they are entitled to. Such subscribers are not guaranteed service benefits and the dollar allowances to which they are entitled are not set forth in the contract.^{8/}

^{8/} As a result these plans have a large demand from subscribers for copies of their fee schedules for, naturally, over-income subscribers want to know the indemnity allowances to which they are entitled.

Indeed such subscribers under most or all of these plans are not guaranteed a fixed and definite benefit. By implication these subscribers are entitled to an indemnity allowance equal to what would be paid to the physician in the case of a subscriber entitled to service benefits. But this indemnity allowance is not a fixed and certain amount. If the plan is paying 100 percent of its fee schedule to participating physicians, then the indemnity allowances are equal to the fees in the schedule. If, however, the plan because of financial difficulties reduced its payments to participating physicians to, say, 80 percent of the scheduled fees, then it is not clear whether subscribers not qualifying for service benefits would be entitled to credits against physicians' charges equal to 100 percent or only 80 percent of the fee schedule.

INDEMNITY ALLOWANCES

At this point in the exposition, the schedules of indemnity allowances given under the plans which provide indemnity benefits in whole or in part might well be set forth, for under these plans these are the benefits provided to subscribers. However, it is useful to compare the indemnity allowances under these plans with the payments made to physicians under the plans providing service benefits. The discussion of payments to physicians comes in the next chapter and hence discussion of the indemnity allowances will be deferred until that chapter.

BENEFITS WHEN SUBSCRIBERS UTILIZE NON-PARTICIPATING PHYSICIANS

All of the service and service-indemnity plans and about half of the indemnity plans provide their benefits through so-called participating physicians. These are physicians who have entered into an agreement with the plan to serve its subscribers and to accept payment therefor from the plan. In most cases these physicians also agree to underwrite the plan financially, that is to accept reduced fees from the plan if necessary while still providing the contractual benefits to subscribers. Under the plans which provide service benefits in whole or in part, participating physicians also agree to accept the plan's fees as full payment for their services to "service" subscribers. Some of the indemnity plans do not have contracts with physicians and thus have no participating physicians.

The majority of the plans with participating physicians provide reduced benefits when the subscriber utilizes a non-participating physician. The reason for this, of course, is the belief that since participating physicians undertake certain obligations towards the plan it would be unfair to these physicians and would lessen inducements to participate if non-participating physicians were accorded the same rights and were paid the same fees.

Some of the plans provide relatively more valuable benefits when the subscriber is served by a non-participating physician outside the plan's area than when he is served by a non-participating physician within the plan's area. Here again the reason is plain: the first physician cannot be expected to participate; the second can be and the plan uses such pressures as it can to make him participate.

Table 26 shows the benefits accorded to subscribers when they utilize non-participating physicians within and without the plan's area.

TABLE 26

Allowances Provided When Non-Participating Physicians Are Used
Data as of December 1946

(Note: These are the allowances set forth in the contracts.
Some plans deviate from these provisions in practice; see text)

	IN PLAN AREA		OUTSIDE PLAN AREA	
	% OF IN-DEMNITY SCHEDULE	% OF FEE PAID PARTICIPATING PHYSICIANS	% OF IN-DEMNITY SCHEDULE	% OF FEE PAID PARTICIPATING PHYSICIANS
ALABAMA	a/	-	a/	-
CALIFORNIA PHYSICIANS' SERVICE	-	0	-	100 b/
OAKLAND	a/	-	a/	-
SACRAMENTO	a/	-	a/	-
COLORADO	-	100 b/	-	100 b/
DELAWARE	80	-	100	-
FLORIDA	-	100 b/	-	100 b/
INDIANA	a/	-	a/	-
IOWA	-	75	-	75
KANSAS	95	-	75	-
LOUISIANA PHYSICIANS SERVICE	c/	-	100	-
NEW ORLEANS, LA.	a/	-	a/	-
MASSACHUSETTS	-	AT LEAST 50 b/	-	AT LEAST 75 b/
MICHIGAN	-	100 b/	-	100 b/
KANSAS CITY, MO.	-	50 b/	-	75 b/
ST. LOUIS, MO.	-	50	100 b/	-
MONTANA	-	0	-	100
NEBRASKA	a/	-	a/	-
NEW HAMPSHIRE-VERMONT	75	-	75	-
NEW JERSEY	-	100	-	100
NEW MEXICO	-	0	-	100
BUFFALO, N. Y.	50	-	100	-
NEW YORK, N. Y.	100 d/	-	100 d/	-
ROCHESTER, N. Y.	50 b/	-	100 b/	-
SYRACUSE, N. Y.	50 b/	-	100 b/	-
UTICA, N. Y.	100 e/	-	100 e/	-
CHAPEL HILL, N. C.	100	-	100	-
HOSPITAL CARE ASS'N., DURHAM, N. C.	a/	-	a/	-
MEDICAL SERVICE ASS'N., DURHAM, N. C.	100	-	100	-
NORTH DAKOTA	-	75 b/	-	100 b/
CLEVELAND, OHIO	a/	-	a/	-
OHIO MEDICAL INDEMNITY	a/	-	a/	-
OKLAHOMA	a/	-	a/	-
OREGON PHYSICIANS' SERVICE	-	100 b/	-	100 f/
OREGON BLUE CROSS PLAN	a/	-	a/	-
PENNSYLVANIA	-	100 b/	-	100 b/
TEXAS g/	a/	-	a/	-
UTAH	-	50 b/	-	75 b/
RICHMOND, VA.	100	-	100	-
ROANOKE, VA.	-	75	-	75
WASHINGTON (KING COUNTY) h/	-	100 b/	-	100 b/
CHARLESTON, W. VA.	-	75	-	75
HUNTINGTON, W. VA.	a/	-	i/	-
MILWAUKEE, WISC.	-	100	-	100

a/ Plan does not have participating physicians; pays all physicians on the same basis.

b/ Services from non-participating physicians paid for only in emergency cases.

c/ Information not available.

d/ Under certain contracts allowances for non-participating physicians' services are limited to 75 percent of what plan would pay participating physicians for the same service. However, it is believed that the plan disregards this in practice and pays non-participating physicians on the same basis as participating ones.

e/ Provisions of surgical indemnity contracts. Under the medical-surgical contract, allowances for non-participating physicians' services are limited to two-thirds the amount the plan pays participating physicians for the same service.

f/ Maximum liability is \$50. for professional services outside the State.

g/ Data as of March, 1946.

h/ Data as of March, 1945.

i/ Plan has no participating physicians. Provisions of contract stipulate that surgical and obstetrical benefits are payable only when the services are rendered by doctors of medicine licensed under the laws of West Virginia.

As regards non-participating physicians within the area, three plans (California, Montana and New Mexico) state in their contracts that benefits are provided only if subscribers are served by participating physicians, i.e., no payment whatever is made for the services of non-participating physicians. Another 12 plans state in their contracts that services of non-participating physicians within the plan's area will be paid for only in cases of accidents or emergency illness. Six of these plans provide that in such cases the non-participating physician will be paid what a participating physician would have received for the same service, another (Massachusetts) provides a payment equal to "at least 50 percent" and the remaining plans pay either 75 or 50 percent of what would have been paid to a participating physician or of the amounts set forth in their indemnity schedule.

Some of these plans do not in practice adhere to these provisions of their contracts. Since June 1946 California Physicians' Service has been paying non-participating physicians at the same rate as participating ones, no question being raised as to whether the service was of an emergency character or not. The Michigan plan, virtually from the beginning, has followed the same policy. The Massachusetts plan has never refused a claim from a non-participating physician and pays all such claims 100 percent. The Colorado plan does not extend participation to osteopaths but pays an approved list of osteopaths at the same rates as participating physicians. It is believed that a few of the other plans construe all cases in which subscribers are served by non-participating physicians as emergency ones and pay 100 percent of what would be payable to a participating physician.

Of the remaining 16 plans with participating physicians, 4 pay non-participating physicians 50 percent, 5, 75 percent and 7, 100 percent either of the amounts in their indemnity schedule (if the contract contains an indemnity schedule) or alternatively (if the plan is on a service or service-indemnity basis and the contract contains no schedule of indemnity allowances) of what would have been paid a participating physician for the same service.

There is a distinction between these last two provisions, i. e., as to whether the plan pays a certain percentage of its indemnity schedule or a certain percentage of what would be paid a participating physician, which it is well to understand. The first gives subscribers a definite benefit when they utilize non-participating physicians and the subscriber knows what it is. The latter does not give subscribers this information and as a matter of fact the benefit is not a fixed and definite one, i. e., if the plan reduced its payments to participating physicians below its regular fee schedule, the credit which a subscriber received when utilizing a non-participating physician would be reduced in the same proportion.^{9/}

As regards payments for the services of physicians outside the plan area: Of the 31 plans with participating physicians, 12 state in their contracts that they will pay for the services of physicians outside the plan area only in cases of emergency. Again it is known that some of these plans disregard this provision in practice. Most of the plans (whether they limit payments to emergency cases or not) will pay 100 percent of what would have

^{9/} It may be noted that by contrast the indemnity allowance which a subscriber to a hospital plan receives when he goes to a non-participating hospital is definite, is set forth in the contract, and does not depend upon what the plan is paying participating hospitals at the time.

been paid to a participating physician or 100 percent of their indemnity allowance schedule; a few pay only 75 percent of one or the other of these amounts.

There have been discussions among the medical plans of the possibility of developing reciprocity arrangements whereby subscribers served in another plan's area would receive service benefits. It is understood that the profession-sponsored plans in seven Western States, under the leadership of CPS, have set up reciprocity arrangements of this character.

CHAPTER 17

PARTICIPATING PHYSICIANS AND PAYMENTS TO THEM: PHYSICIAN GUARANTEE OF BENEFITS

Most of the plans provide service through participating physicians. What physicians or practitioners are eligible to participate?

This is determined in the first instance by the relative provisions, if any, of the enabling act under which the plan operates. As will be shown in more detail in Chapter 18 about half of the present enabling acts restrict participation to doctors of medicine. Some of these acts stipulate that participation shall be limited to duly licensed physicians, a term which in some States would include osteopathic physicians. A few specify that doctors of medicine and osteopaths may participate or prohibit any discrimination between schools of practice. A few of the acts specify that all physicians or all qualified physicians in the area shall have the right to participate.

The great majority of plans permit any licensed doctor of medicine to participate and restrict participation to such individuals. The exceptions to this general rule are few. The New Hampshire-Vermont plan extends participation only to members of the medical societies of the two States.^{1/} The Milwaukee plan limits participation to members of the State society. It is believed that the plans in the State of Washington have a similar rule. The Utica plan states that doctors of medicine and osteopaths may participate. The other plans in New York State permit "any duly licensed physician" to participate, and it is believed that under the laws of this State this phrase would include osteopathic physicians. California Physicians' Service and the Colorado and Michigan plans restrict participation to doctors of medicine but in practice pay osteopaths on the same basis as doctors of medicine.

In many places the inclusion or exclusion of osteopaths has been a source of difficulties and controversy. California Physicians' Service formerly excluded osteopaths. However, the latter are numerous and have a considerable following in this State and it was found that this rule impeded presentation of the plan to the public. Hence in 1946 the California Medical Association voted to pay for service rendered by osteopaths. In Kansas City, Mo. a considerable part of the population uses the services of osteopaths as is indicated by the fact that the number of these practitioners is one-half as great as the number of doctors of medicine. Osteopaths are not permitted to participate in the plan, as a result of which they have advised their patients not to join the plan. Undoubtedly the hostility of the osteopaths has slowed down the growth of both the medical plan and the hospital plan (which excludes osteopathic hospitals) of this city.

^{1/} This was true of the New Hampshire plan before it was expanded to Vermont and it is believed that the same rule still applies.

In Maine there is one osteopath for every two doctors of medicine. It is probable that a plan which did not permit patients to use osteopaths would not have wide public acceptance. The physicians of the State have been unwilling to start or sponsor a plan which would be open to osteopaths, with the result that thus far no plan at all has been established.

In Rhode Island the medical society wishes to start a plan which would exclude osteopaths and wants the Rhode Island Blue Cross plan to administer this plan. The latter refuses to administer any plan which would exclude osteopaths on the ground that it does not feel free to deny to its subscribers the right to have the services of any legally qualified surgeon. For over a year this deadlock has prevented the establishment of a plan.

It is also of interest to consider what practitioners may provide service under the plans which do not have participating physicians. With possibly one exception these plans will only provide their benefits when the subscriber is served by a doctor of medicine.^{2/} Two of these plans, the New Orleans and Alabama plans, go further and provide that the subscriber must be served by a physician who is a member of his county medical society.

EXTENT TO WHICH PHYSICIANS ARE PARTICIPATING

Medical plans face a different problem than hospital plans in obtaining the participation of those giving service. Most hospital plans do not have more than 50 or 100 hospitals in their area and once the terms of participation have been agreed upon between the plan and a committee representing the hospitals, it is relatively easy for the plan to secure the participation of the hospitals in its area. In the great majority of the plans, all of the recognized hospitals in the area are participating.

It is otherwise with the medical plans. Here the number of physicians whose participation should be won often runs into the thousands. There are difficulties in the way of reaching all of these individuals and explaining the plan to them. The fact that the medical society has launched or endorsed the plan by no means assures that all or even a large proportion of the physicians will participate. In general it is only as (a) the medical society actively and enthusiastically pushes the plan and exhorts physicians to participate, and (b) individual physicians become convinced that the operation of the plan will be both helpful to the public and advantageous to themselves, that substantial participation is obtained.

Accurate figures for the various plans on the extent to which all active practitioners in the area have agreed to participate are hard to obtain, are often misleading and become quickly obsolete. It is for example more important for a surgical plan to have the participation of surgeons who are doing most of the surgical work than of, say, pediatricians who are doing very little surgery. A state-wide plan may show an average participation of, say, only 80 percent, but it may have almost 100 percent participation in those areas in which it is actively selling contracts, and small participation in other areas where it has not yet become active.

Table 27 gives data for certain of the plans, including most of the older ones, on the extent of participation. It will be seen that the extent of participation (in general as of December 1946) ranges from 33 percent in

^{2/} The possible exception may be the Indiana plan which provides benefits when subscribers are served by physicians, a physician being defined as one "holding an unlimited license to render unlimited medical or surgical service."

Iowa, where the plan is relatively new to practically 100 percent in Delaware and Roanoke.

TABLE 27			
Percent of Active Physicians of the Area Participating in Medical Plans			
Data for Certain Plans, Various Dates			
PLAN	BASIS OF PLAN (Service or Indemnity)	DATE OF INFORMATION	PERCENT OF PHYSICIANS REPORTED TO BE PARTICIPATING
CALIFORNIA PHYSICIANS' SERVICE	S-I	DEC. 1946	82
COLORADO	S-I	DEC. 1946	83 ¹ / ₁
DELAWARE	I	AUG. 1945	PRACTICALLY 100
IOWA	S-I	DEC. 1946	ABOUT 33 ² / ₁
KANSAS	S-I	DEC. 1946	ABOUT 90
MASSACHUSETTS	S-I	DEC. 1946	92
MICHIGAN	S-I	DEC. 1946	75
KANSAS CITY	S-I	DEC. 1946	97
NEW HAMPSHIRE	I	DEC. 1945	68 ³ / ₁
NEW JERSEY	S-I	FEB. 1946	82
BUFFALO	I	DEC. 1945	95
NEW YORK CITY	S-I	DEC. 1946	65 ⁴ / ₁
NORTH DAKOTA	S	DEC. 1946	95 ⁵ / ₁
ROCHESTER	I	JAN. 1947	86 ⁶ / ₁
OREGON PHYSICIANS' SERVICE	S	DEC. 1946	92 ⁷ / ₁
PENNSYLVANIA	S-I	NOV. 1946	MORE THAN 50 ⁸ / ₁
ROANOKE, VA.	S	DEC. 1946	PRACTICALLY 100
WASHINGTON, VARIOUS COUNTY PLANS	S	FEB. 1945	80 - 100

¹/ Of members of State Medical Society. Participation in Denver to which the plan formerly confined operations is close to 100 percent. Extent of participation outside Denver is rapidly increasing.

²/ Most of the participating physicians are located in certain cities. Reasons for low participation are not known, except that the plan is relatively new.

³/ Percent of participation in various counties ranged from 94 percent to 36 percent.

⁴/ The main reason for low participation is the large number of physicians in the area and the difficulty of reaching them - there are 17 county medical societies and many physicians do not attend meetings. Few if any physicians have refused to participate. It is mainly that the plan has not been brought effectively to their attention.

⁵/ Plan thus far is operating in Cass County. Here 95 percent of all members of the medical society are participating.

⁶/ In five counties. Physicians in another county have not yet voted whether to participate or not.

⁷/ It is believed that some of the non-participating physicians are obstetricians and pediatricians who have not participated in the past because their services were not covered.

⁸/ Plan has been in effective operation only a short period. Extent of participation has been held back by differences between some of the county societies and the state society, and the inability of the plan and the Blue Cross plans to reach a satisfactory cooperative arrangement.

The situation in certain areas calls for special comment. In California there has been a reluctance on the part of some physicians to participate because the plan all along has paid less than its scheduled fees. The physicians of certain counties have voted in their county societies not to participate, holding that the plan should be on an indemnity basis. However,

in 1946 the physicians of the Sacramento area who for seven years held out against CPS voted to participate. In Michigan right from the start the physicians of certain counties refused to participate, holding that the plan should be on an indemnity basis. However, many of the physicians in these counties are "cooperating" with the plan even though not formally participating. In various other plans differences of opinion as regards the principle of "service" or "indemnity" have at one time or another held back participation.

In general, and as one would expect, the extent of participation is somewhat higher in the plans that are on an indemnity basis than in those on a service basis in part or in whole. However, this factor is by no means a determining one, as may be seen from the fact that of the two plans which have practically 100 percent participation one is on a straight indemnity and the other on a full service basis. Certain of the indemnity plans have not been able to obtain 100 percent participation of the physicians in their area; the dissenting physicians are against prepayment in principle, or have no interest whatever in it, or find the plan faulty in some detail. In most plans with relatively low participation the main explanation is that the plan is new and has not been enthusiastically supported by the medical society or societies of the area.

In a letter written in December 1946 to the executive directors of representative plans the writer asked these individuals to give the main reasons for non-participation. The plan directors were further asked to indicate the character of non-participating physicians -- were they the more qualified or less qualified physicians, the high priced specialists or general practitioners, the rural or urban physicians, etc.

The replies indicated that the non-participating physicians could not be placed in any single category. Some of these physicians were men just returned from military service who had not yet become familiar with the plan. Several of the executive directors stated that most of the non-participating physicians were older men who were not interested in anything new and whose ideas of medical economics were behind the times. Some of the comments may be quoted: "The physicians who are not participating are the older ones... and a few prima donna specialists... Participation is approximately the same in rural and urban areas." "In general the physicians who are not participating are those who are not aware of the plan...The high priced specialists were among the first to execute the participating physicians agreement....So far as I know there is no tendency on the part of any type of practitioner, specialist or general practitioner...to withhold participation."

"The physicians who are not participating are those who are against the prepaid movement, those who are too busy with their own private practice, and those who are going to retire soon... These men are the average physicians, not the poorer ones or the specialists or the general practitioners."

"In the main the non-participating ones are those who are not familiar with the program... There are fewer than a half dozen high pressure specialists who have explicitly stated that they are not interested. I do not believe it is a matter of higher fees with them, rather that they are so tremendously overburdened that they feel, erroneously of course, that participation would give them added volume which they cannot physically handle."

"I am sure our participating physicians are at least average...practically all the top men are enrolled."

PAYMENTS TO PARTICIPATING PHYSICIANS

To set forth and compare for all of the plans the fees paid for the multitude of surgical and other procedures would be neither feasible nor useful. However, the general level of the payments to physicians can be indicated by the fees paid for certain of the more common procedures or services. The data are set forth in Table 28.

In comparing the fees paid by the different plans, it should be borne in mind that in the case of subscribers entitled to service benefits, the payments represent the entire payment to the physician, whereas in other cases, the fees allowed are in the nature of credits against the physician's charge. Except in Washington, Oregon, California and Buffalo the plans have currently been paying 100 percent of their fee schedules. The plans in Washington and Oregon have been paying, it is believed, about 90 or 95 percent of their fee schedules. California Physicians' Service has been paying at the rate of 80 or 90 percent of its fee schedule. The Buffalo plan temporarily reduced payments to its physicians in 1946 because of financial difficulties stemming from coverage of home and office calls.

The fee or indemnity allowance most commonly paid for a normal delivery is \$50. The two North Carolina plans both pay only \$25.00 for this service under their lower cost contracts, more under their higher cost contracts. A few plans pay \$40, including Massachusetts. (Under this latter plan general practitioners agree to accept this fee as full payment for "service" subscribers, but specialists in obstetrics may make a specified extra charge.) A few plans pay \$60 or \$75 for a delivery. California Physicians' Service pays \$100. Most of the plans pay either \$75 or \$100 for an appendectomy, - the lowest payment is \$50, the highest \$125. Most of the plans pay either \$75 or \$100 for a unilateral hernia operation, the range being between \$50 and \$110. The plans commonly pay \$3.00 or \$2.00 for a hospital call or office visit and a dollar more for a home call. Some of the plans pay higher fees for the initial than for subsequent calls.

RELATIONSHIP BETWEEN PLAN PAYMENTS AND PHYSICIANS' CHARGES

In the case of the indemnity and service-indemnity plans interest attaches to the relationship between the plan's payments or indemnity allowances and physicians' charges to subscribers. This relationship, of course, indicates the degree of protection given subscribers by these plans. Data are available for only a few plans.

Table 29 provides data from the Delaware plan which is on a straight indemnity basis. During the first 9 months of 1946 the plan's payments covered the doctor's charge in full in 68 percent of the cases and in the aggregate met 74 percent of total charges.

During the year 1945 plan payments covered doctors' charges in full in 72.5 percent of all cases and met 76 percent of total charges.

TABLE 28

Fees Paid or Indemnity Allowances Provided for Certain Services. Data as of December, 1946.

PLAN	TYPE OF BENEFIT	AMOUNT FOR									
		APPEN- DECTOMY	SINGLE HERNIA	CHILD'S TONSIL- LECTOMY	NORMAL DELIVERY	HOSPITAL CALLS		OFFICE CALLS		HOME CALLS	
						FIRST	SUBSEQUENT	FIRST	SUBSEQUENT	FIRST	SUBSEQUENT
Alabama	I	\$ 100.	\$ 75.	\$ 25.	\$ 50.	\$ 2.	\$ 2.	\$ 5.00	\$ -	\$ -	\$ -
California Physicians' Service	S-I	125.	100.	40.	100.	3.75	3.75	5.00	2.50	5.00	3.75
Oakland, Cal.	I	125.	60.	35.	-	3.	3.	-	-	-	-
Sacramento, Cal.	I	100.	50.	30.	50.	-	-	-	-	-	-
Colorado	S-I	75.	75.	25.	50.	-	-	-	-	-	-
Delaware	I	100.	75.	25.	50.	-	-	-	-	-	-
Florida	S-I	100.	100.	25.	50.	3.	3.	-	-	-	-
Indiana	I	100.	50.	25. <u>a/</u>	50.	10.	3.	-	-	-	-
Iowa	S-I	100.	75.	25.	55.	5.	3.	-	-	-	-
Kansas	S-I	100.	75.	35.	50.	-	-	-	-	-	-
Louisiana Physicians Service	S-I	100.	75.	35.	50.	-	-	-	-	-	-
New Orleans, La.	I	100.	75.	25.	50.	-	-	-	-	-	-
Massachusetts	S-I	75.	75.	25.	40.	5.	3.	-	-	-	-
Michigan	S-I	75.	75.	30.	40.	-	-	-	-	-	-
Kansas City, Mo.	S-I	100.	75.	35.	75.	3.	3.	-	-	-	-
St. Louis, Mo.	I	100.	75.	25.	50.	3.75	3.75	-	-	-	-
Montana	S-I	125.	100.	50.	50.	3.	3.	-	-	-	-
Nebraska	I	100.	100.	35.	50.	3.	3.	-	-	-	-
New Hampshire-Vermont	I	75.	75.	25.	40.	2.	2.	2.	2.	3.	3.
New Jersey	S-I	100.	75.	40.	50.	5.	3.	-	-	-	-
New Mexico	S-I	-	-	-	-	-	-	-	-	-	-
Buffalo, N. Y.	I	75.	75.	30.	50.	-	-	-	-	-	-
New York, N. Y.	S-I	100.	75.	25.	60. <u>c/</u>	3.	3. <u>d/</u>	2.	2.	3.	3.
Rochester, N. Y.	I	75.	75.	30.	50.	-	-	-	-	-	-
Syracuse, N. Y.	I	75.	75.	25.	50.	2.	2.	2.	2.	3.	3.
Utica, N. Y. <u>e/</u>	I	75. <u>f/</u>	50. <u>f/</u>	25. <u>f/</u>	50.	2.	2.	2.	2.	3.	3.
Chapel Hill, N. C. I	I	60.	50.	17.50	25.	-	-	-	-	-	-
II	I	75.	75.	25.	40.	-	-	-	-	-	-
Hospital Care Ass'n., Durham, N. C. <u>g/</u> I	I	50.	50.	15.	25.	-	-	-	-	-	-
II	I	100.	75.	25.	50.	-	-	-	-	-	-
Medical Serv. Ass'n., Durham, N. C. <u>h/</u>	I	50.	50.	-	25.	2.	2.	2.	2.	3.	3.
North Dakota	S	100.	75.	35.	50.	-	-	-	-	-	-
Cleveland, Ohio	I	100.	50.	25.	60.	-	-	-	-	-	-
Ohio Medical Indemnity	I	100.	75.	25.	50.	-	-	-	-	-	-
Oklahoma	I	100.	75.	25.	50.	-	-	-	-	-	-
Oregon Physicians' Service	S	100.	85.	35.	50.	4.	2.50	3.50	2.50	5.	4.
Northwest Hosp. Service, Oregon	I	125.	60.	35.	50.	3.	3.	-	-	-	-
Pennsylvania	S-I	100.	75.	25.	50.	5. <u>i/</u>	3.	-	-	-	-
Texas <u>j/</u>	I	75.	75.	25.	50.	3.	3.	-	-	-	-
Utah	S-I	125.	100.	35.	50.	-	-	-	-	-	-
Richmond, Va.	S-I	75.	75.	25.	50.	5.	3.	-	-	-	-
Roanoke, Va.	S-I	75.	75.	25.	50.	-	-	-	-	-	-
Washington (King County) <u>k/</u>	S	100.	110.	35. <u>l/</u>	75.	3.50	2.	3.50	2.	4.	4.
Charleston, W. Va.	I	75.	50.	25.	50.	3.	3.	-	-	-	-
Huntington, W. Va.	I	75.	50.	25.	50.	-	-	-	-	-	-
Milwaukee, Wis.	S-I	100.	75.	35.	50.	3.	3.	-	-	-	-

a/ With general anesthetic; with local anesthetic, \$35.

b/ Data not available.

c/ Participating physicians can charge extra. Other con-
tracts of this plan provide \$75.00 for normal deliveries.

d/ \$3.00 per day for the 4th through the 21st day of hos-
pitalization, then \$10.00 per week through the 11th day.

e/ Fees shown are for higher cost contract.

f/ For dependents, one-half of these indemnity allow-
ances are paid by the plan.

g/ Plan also has intermediate schedule.

h/ For Farm Security Administration borrowers.

i/ \$5.00 per day for first two days.

j/ Data as of March 1946.

k/ Data as of March 1945.

l/ If performed in hospital. In office, \$50.

TABLE 29
Comparison of Plan Payments and Doctors' Charges,
Delaware Surgical Plan, Jan. 1 - Sept. 26, 1946

	PERCENT OF TOTAL CASES PAID IN FULL	PERCENT OF TOTAL CHARGES PAID
SURGICAL PROCEDURES	54.5	73.7
X-RAY	73.2*	73.6*
ANESTHESIA	81.0	80.1
TRANSFUSIONS	90.0	80.2
ALL CASES	68.1	74.1*

*Part of the charges for x-ray service are paid by the hospital plan. Payments made by the hospital plan are included where x-ray claims are paid in full but are not included where they are not paid in full. Together the two plans met approximately 90 percent of doctors' charges for x-ray service.

Under this plan there is a wide variation in the ratio of plan payments to doctors' charges by type of surgery or procedure. Thus in fracture cases plan payments met 90 percent of total charges, in appendectomies 89.5 percent, in female genital cases 80.1, in deliveries 71.5, in tonsil and adenoid cases 62.5, in eye cases 53.9, and in cases involving surgery of the mouth other than tonsil and adenoid cases, 43.7. Obviously this plan's indemnity schedule is closer to the standard or average charges for certain operations or procedures than for others.

Data are available for the Buffalo N. Y. plan for the period September 1944 to February 1945. During this period the plan's payments met 81.3 percent of the physicians' charges in medical cases (at that time the plan covered home, office and hospital calls), 70.9 percent in surgical cases, 72.6 percent in gynecological cases, 72.3 percent in maternity cases, and for all cases together 76 percent of the aggregate of physicians' charges.

The New Hampshire Plan (also straight indemnity basis) reports that from its inception up to August 1945, its payments covered 84.4 percent of the total of physicians' charges for surgery and obstetrics, 77.4 percent of the charges for anesthesia, 100 percent of the charges for x-ray service and for all services together 84.1 percent. The 1946 annual report of the plan states that in many areas physicians are accepting the plan's allowances as full payment in the case of all subscribers, and that complaints from subscribers of extra charges on the part of physicians are rare.

One indemnity plan made a study in 1945 of a sample of its claims. This plan at that time had an indemnity schedule which was the same as that used by insurance companies and which these companies had found low for the area in question. It was found that the plan payment covered the physician's charge in full in 19.3 percent of all cases, met from 80 to 99 percent of the charge in 2.8 percent of the cases, met from 60 to 79 percent of the bill in 33.2 percent of the cases, from 40 to 59 percent of the bill in 24.7 percent of the cases, and met less than 40 percent of the bill in 20 percent of the cases. The plan payments met a larger portion of the charge in cases carrying a high scheduled payment than in cases with a low scheduled payment, and for all cases together it appeared that the plan was meeting about 65 percent of the total of doctors' charges.

The New Jersey plan (service-indemnity basis) reports that for November and December 1945 the plan payments met the doctors' charges in full in 57.7 percent of the cases and covered about 80 percent of the aggregate of physicians' charges.

Data for no other plans are available. The executive directors of some of the service-indemnity plans report that some physicians currently accept

the plan's payments as full payment for all subscriber-patients. Some plans receive numerous complaints from subscribers, who are over the income ceilings for service benefits, of extra charges by physicians. (This matter will be discussed in more detail in a later chapter.) However, the plans apparently have no data showing what the situation really is, and the degree of protection afforded by these plans to those of their subscribers not entitled to service benefits remains a mystery.

In sum, under 4 indemnity plans and one service-indemnity plan the degree of protection, at various periods in the past, has ranged from about 65 to 85 percent.

ADEQUACY OF PAYMENTS TO PHYSICIANS

It is difficult to appraise the adequacy of the fees or indemnity allowances paid under the plans. It must be borne in mind of course that under the indemnity plans or as regards the subscribers of the service-indemnity plans entitled only to indemnity benefits, the fees paid do not necessarily represent the total received by the physician.

One way of appraising the adequacy or fairness of these fees might be to compare them with the fees regularly charged by physicians to non-plan patients, or the fees actually collected from such patients ^{3/} Unfortunately data for such a comparison are not available.

One possible test of the adequacy or inadequacy of the scheduled fees or indemnity allowances is provided by comparison with the fees paid under the Veterans Administration "Home Town" medical care program. These latter fee schedules have been jointly negotiated between the State medical society and the Veterans Administration and presumably represent levels of remuneration which are fair both for the government and the medical profession. This comparison is made for six plans in Table 30.

In the case of California Physicians' Service, in seven out of nine selected procedures the fees payable by the plan (before proration) are identical with those paid by the Veterans Administration. In one operation the CPS fee is lower than the VA fee; in another instance it is higher. In general the two schedules are the same. Physicians accept the VA fees as full payment for all veterans; they agree to accept the CPS fees as full payment only for those with incomes under \$3,000. This comparison would seem to indicate that the CPS schedule is high as it applies to persons with incomes under \$3,000 or, alternatively, that the profession could fairly accept these fees for the entire subscribing public, irrespective of income. However, it must be borne in mind that CPS has never paid its scheduled fees 100 percent.

In the case of the Michigan plan the plan's fees and the VA's fees are identical in 8 out of 9 operations, and in one the VA fee is higher by 20 percent. Roughly therefore the VA schedule can be regarded as about 2 or 3 percent higher overall than the plan's schedule. On the basis of the same reasoning as above, and assuming that the VA schedule represents fair remuneration, Michigan's schedule can be regarded as high for the income groups entitled to service benefits, or alternatively physicians should be willing to accept these same fees for all subscriber-patients.

^{3/} A survey in 1929 found that physicians collected 81.5 percent of their charges. (Leven, Maurice, *The Incomes of Physicians*, Committee on the Costs of Medical Care, Publication No. 24, University of Chicago Press, 1932.)

TABLE 30

Comparison of Fees or Indemnity Allowances Paid for Specified Services by Medical Service Plans in Various States and Fees Paid by the Veterans Administration in these States.
(Data as of August 1946)

PLAN	APPENDECTOMY	HERNIOTOMY (SINGLE)	CHOLECYSTECTOMY	DELIVERY	HYSTERECTOMY	HEMORRHOIDECTOMY (INTERNAL)	PROSTATIC RESECTION TRANSURETHRAL	THYROIDECTOMY	TONSILLECTOMY (ADULT)
CALIFORNIA CALIFORNIA PHYSICIANS' SERVICE	\$ 125.00	\$ 100.00	\$ 200.00	\$ 75.00	\$ 150.00	\$ 75.00	\$ 100.00	\$ 175.00	\$ 60.00
V. A.	125.00	100.00	200.00	75.00	150.00	100.00	100.00	175.00	50.00
KANSAS KANSAS PHYSICIANS SERVICE	100.00	75.00	150.00	50.00	125.00 d/	50.00	100.00	125.00	35.00
V. A.	100.00	75.00 a/	150.00	5/	150.00 d/	75.00	125.00	150.00	35.00 h/
MICHIGAN MICHIGAN MEDICAL SERVICE	75.00	75.00	140.00	40.00	150.00 d/	50.00	100.00	125.00 g/	30.00
V. A.	75.00	75.00	140.00	40.00	150.00	60.00	100.00	125.00	30.00
NEW JERSEY NEW JERSEY MEDICAL SURGICAL PLAN	100.00	75.00 a/	125.00	50.00	150.00	50.00	100.00	125.00	40.00
V. A.	100.00	100.00	140.00	50.00	150.00	62.50	100.00	125.00	40.00 h/
OHIO OHIO MEDICAL INDEMNITY, INC.	100.00	75.00	125.00	50.00	150.00	50.00	150.00	150.00	35.00
V. A.	100.00	100.00	150.00	5/	150.00	50.00	150.00	150.00	40.00 h/
NORTH CAROLINA HOSPITAL SAVINGS ASSOC. OF NORTH CAROLINA	60.00	50.00	75-100.00 b/	25.00	75.00	25.00 g/	50.00	75.00	17.50
\$100.00 SCHEDULE	75.00	75.00	75-150.00 b/	40.00	100.00	35.00 i/	75.00	100.00	25.00
\$150.00 SCHEDULE	75.00	75.00	140.00	40.00	150.00	62.50 g/	100.00	125.00	30.00
V. A.									

- a/ Ventral \$100.00
b/ Grouped with other abdominal operations
c/ Not listed
d/ Vaginal or abdominal
e/ Does not state whether internal or external
f/ External
g/ One stage, sub-total
h/ Extra fee paid if adenoidectomy performed at the same time.

The VA schedule for Kansas is somewhat higher than that of the Kansas plan and the same is true for New Jersey and Ohio. The VA schedule for North Carolina is appreciably higher than the higher of the two indemnity schedules of the North Carolina plan. In comparison with the VA schedules the schedules of all four plans, regarded as minimums, would not seem to be excessive.

In Oregon the fee schedule of Oregon Physicians' Service and that of the VA are identical. The same is true for Montana. On the same reasoning as above, the fee schedule of Oregon Physicians' Service, being a full service plan can be regarded as reasonable; that of the Montana plan, holding as it does only for those with incomes under \$4,000, might seem to be a little high.

These observations must obviously be accepted with caution. The yardstick employed is one which changes from State to State.

Another possible approach to an evaluation of the fee or indemnity schedules of these medical plans is to compute what these payments would mean in terms of income to the profession if the whole population of the area were enrolled in the plan. This may be done by assuming that the subscription costs of the plan are fixed so as to support the given fee schedule, and that subscription costs per subscriber, after deduction of reasonable allowances for administrative costs and additions to reserves, represent income to the profession.

The New Jersey plan estimates that its income from subscribers equals \$.67 per person a month. If the whole (1940) population of the State were enrolled the plan's income would be approximately \$33,447,000 a year. Assuming that administrative expenses and additions to reserves will in the long run require 20 percent of this amount, there would be left approximately \$26,757,000 as income for the profession, - an amount which divided among the approximately 4700 (pre-war) active private practitioners of the State would give each an annual gross income of \$5693 a year. This would yield a net income of about \$3400. This income would be derived from surgery, obstetrics and hospital calls on medical cases, services from which the profession probably now derives only about a third of its income, the remainder coming from office and home calls. It would appear from this that if the whole population of the State were enrolled at present subscription rates and the profession received 80 percent of the plan's gross income, the profession would do well financially, even if no extra charges were made to subscribers over the income limits for service benefits. There is one qualification which must be made to such a calculation: the total volume of medical work would probably be considerably greater under the assumed conditions and the present physicians might have to work considerably harder, or an increased number of physicians would be needed. If this last were true the average income per physician would be reduced.

A similar calculation may be made for Michigan. In 1945 officials of the plans estimated that if the whole population were enrolled at the then present subscription rates the plan's income (after deduction of 20 percent for administration and additions to reserves) would yield each active private practitioner in the State an annual gross income of about \$5600. This income would have been derived from surgical, obstetrical, x-ray and anesthesia service in hospitals. The analogous figure at the plan's present subscription rates (\$3.25 per family) for the surgical, obstetrical and hospital call contract would be about \$8000 for an expanded scope of service.

In general it appears that the medical profession would fare well financially if the whole population were enrolled in these plans.^{4/}

PHYSICIAN GUARANTEE OF BENEFITS

Medical prepayment, like hospital prepayment, is based on the principle of insurance. The plan receives from its subscribers certain periodic payments in return for which it obligates itself to provide these subscribers with certain services or benefits as the need for these arises. It is of the greatest importance, naturally, that the plan should not default upon its obligations to subscribers - having received their subscriptions it must be in a position at all times to carry out its obligations to them and to provide the contractual benefits or services. The special characteristics of insurance and the need for protection of the public has led in all States to public regulation and supervision of the insurance business.

There are three ways by which the soundness of medical plans -- their ability to provide the contractual benefits to their subscribers -- can be assured.

The first method is by the plan having capital and reserves of an amount sufficient to carry it through any temporary period in which benefit expense plus the cost of administration exceeds income, and to give it time to adjust its rates and benefits, if need be, so as to regain a financially sound position.

The second method is through agreement of the participating physicians to provide the contractual services or benefits to subscribers even though the plan is unable to pay physicians at its scheduled rates. Under this situation the plan's resources are in effect augmented by the resources of all the participating physicians.

A third possible method by which the delivery of benefits to subscribers may be guaranteed is through the agreement of subscribers to pay special assessments if the financial situation of the plan so requires. This method of underwriting is the one generally used by so-called mutual insurance companies, although many such companies after they have accumulated sufficient reserves to assure their financial stability eliminate the liability of policy holders to assessments. While the liability of subscribers to assessments seems, on paper at least, an effective means of guaranteeing the ability of a plan to provide its scheduled benefits, one may doubt whether in practice this guarantee adds anything more than is given by a plan's ability readily to adjust its rates and benefits. Subscribers to a medical plan, unlike the policy holders of a life insurance company, are not held to the plan by long term contracts. In practice many subscribers would probably drop out when asked to pay a special assessment and, in any case, the time required by the plan to levy and collect a special assessment would probably be as great as that required to institute a change in rates and benefits.

Medical plans are as yet very largely in an experimental stage and the possibility that any plan may get into financial difficulties is not at all remote. Hence it would seem essential for the protection of the subscrib-

^{4/} A Department of Commerce survey found that in 1941 physicians in private practice had an average net income of \$5,047. (Incomes in Selected Professions, Survey of Current Business, October 1943.) The magazine Medical Economics found that in 1943 non-salaried physicians had an average net income of \$9,186. (Medical Economics, February 1945, p. 45.)

ing public that such plans should be firmly underwritten in one way or another. The importance of this is indicated by the history of several of the existing plans which have run into financial difficulties in the past and would probably today not be in existence except for the fact that they were underwritten by their participating physicians.

What is the current situation regarding the underwriting of medical plans?

Of the 42 plans (as of Jan. 1, 1947) for which full data are available 20 are definitely and firmly underwritten by their participating physicians.^{5/} In these plans the participating physicians agree to provide the specified services or indemnity credits to subscribers even though the plan is unable to make its scheduled payments to physicians. The physicians further agree not to cancel their participation except on a year's notice, or, if cancellation on shorter notice is permitted, to provide the specified services and credits to subscribers during the remainder of the contract year on then-existing contracts or until such contracts can be cancelled.

Three of these plans (CPS, Oregon Physicians' Service and the plans in Washington) use proration of fees as a current part of their operations. The other plans in this group as well as all the other plans aim to build up reserves to provide the initial defense against an unfavorable experience, relying upon the underwriting by participating physicians as a second defense.

In eight other plans there is some degree of underwriting by participating physicians.^{6/} The participating physicians of these plans agree to provide the service or credits and to accept reduced fees if necessary. However, the contracts with participating physicians permit these physicians to withdraw on short notice - 15 or 30 days - or no notice at all.^{7/} If a plan so situated should reduce its payments to physicians and all or any large number of the participating physicians withdrew from the plan, there would, of course, be no effective underwriting. In practice, it is highly improbable that most or many of the physicians would withdraw if the plan reduced its payments. Probably they would continue to provide the service. Nevertheless, from a contractual standpoint the plan is not firmly underwritten.

Fourteen of the plans are not underwritten in any way by the medical profession.^{8/} These plans do not have participating and non-participating physicians. All of them are on a straight indemnity basis and they pay the same indemnity allowances to all physicians in or out of their area.

Of these 14 plans, three are organized as mutual insurance companies and are presumably underwritten by their subscribers since the latter are liable to assessments.^{9/} Three other plans are also organized as mutual insurance companies, but are not underwritten by their subscribers, the latter not being subject to assessments.^{10/} Presumably this is because these plans

5/ California Physicians' Service, Delaware, Iowa, Kansas, Massachusetts, Kansas City, Montana, New Hampshire, New Jersey, New Mexico, Buffalo, Rochester, Syracuse, Utica, North Dakota, Oregon Physicians' Service, Richmond, Roanoke, Milwaukee, and the plans in Washington. It is not altogether certain that Kansas belongs in this group as the underwriting obligation is a little indefinite.

6/ Colorado, Louisiana, Michigan, New York City, Medical Service Assoc. of Durham, Pennsylvania, St. Louis, and Charleston.

7/ Colorado, 30 days; Louisiana, 30 days; Michigan, 15 days; Medical Service Assoc. of Durham, 30 days; Pennsylvania, 30 days; St. Louis, 30 days; New York City, no notice; Charleston, 30 days.

8/ Alabama, Sacramento, Oakland, Indiana, New Orleans, Nebraska, Hospital Care Assoc. of Durham, Hospital Saving Assoc. of Chapel Hill, Ohio Medical Indemnity, Cleveland, Oklahoma, Northwest Hospital Service of Oregon, Texas and Huntington.

9/ Indiana, Oklahoma and Nebraska.

10/ Cleveland, Sacramento, and Texas.

have sufficient capital or reserves so that they are permitted under the laws of their State to issue policies without contingent liability of the policy holders. One plan (Ohio Medical Indemnity, Inc.) is organized as a stock insurance company; it is underwritten so to speak by its contributed capital.

The remaining seven plans in this group are all joint hospital-medical plans.^{11/} Two of these plans (New Orleans and Oregon) and possibly another (Huntington) are underwritten by their member hospitals, which means that the hospitals are also responsible for the obligations of the medical contracts; three plans (Durham, Oakland and Chapel Hill) are not underwritten by the hospitals and for one plan (Alabama) definite information on this point was not available.

It will be seen from this review that about two-thirds of the present medical plans are financially backed up by the medical profession, although in some of these plans the underwriting is not contractually secure. The proportion of medical plans underwritten by the medical profession is about the same as the proportion of hospital plans underwritten by the hospitals. It would seem that in order to protect the subscribing public the insurance departments of the various states should see that medical plans which are not firmly and definitely underwritten by the medical profession (or by hospitals) should have reserves of an amount which would permit them to do business if organized as mutual or stock insurance companies under the State law. In other words medical plans should be firmly underwritten by the medical profession (or by hospitals - if hospitals wish to undertake this obligation) or they should have sufficient capital or reserves to give the subscribing public adequate assurance that they will not default upon their obligations.

In connection with the underwriting of plans by the medical profession the following factor needs to be taken into consideration. The underwriting of a plan by its participating physicians is practicable when the plan provides service benefits, but the same conclusion might not hold when the plan provides indemnity benefits in whole or in part. Under the latter type of plan, if prorating had to be resorted to, some physicians might increase their charges to subscriber-patients in order to make up for the reduction in fees paid by the plan. For example, if the scheduled indemnity benefit or credit for a certain operation was \$100, but under proration physicians received only \$90, some physicians might increase by \$10 the charge that they might otherwise make to these patients. To the extent that this happened in practice, it would be the public and not the profession which was really underwriting the plan.

^{11/} Alabama, Oakland, New Orleans, Hospital Care Assoc. of Durham, Hospital Saving Assoc. of Chapel Hill, Northwest Hospital Service (of Oregon) and Huntington.

CHAPTER 18

LEGAL STATUS OF MEDICAL PLANS*

The provision of medical service on a prepayment basis is an activity of the same general nature as the provision of hospital service on a prepayment basis, and the legal status of non-profit plans offering medical service is identical with or similar to that of hospital service plans.

Most of the hospital service plan acts passed previous to 1943 did not permit these plans to offer medical service contracts. Hence, when the medical profession and civic groups desired to establish medical prepayment plans, they found it necessary or desirable, in most States, to request the passage of legislation which would permit the establishment of medical service plans as separate organizations or would permit the existing hospital service plan or plans to broaden the scope of their activity and offer medical service as well. In the last two or three years several of the States which did not previously have enabling acts for hospital plans have adopted legislation which would enable the formation of hospital or medical plans, or both, or combined hospital and medical plans.^{1/}

The first legislation authorizing medical prepayment by non-profit plans was passed in 1939. To date such legislation has been enacted in 26 States. The States having such legislation and the years in which the initial laws were passed are as follows:

1939: California*, Connecticut, Michigan, New York,
Pennsylvania and Vermont
1940: New Jersey and Virginia*
1941: Massachusetts and Ohio
1942: - - - - -
1943: Maine*, New Hampshire, North Carolina*, West Virginia
1944: - - - - -
1945: Alabama*, Arizona*, Florida*, Illinois, Iowa, Kansas
Maryland*, Minnesota, North Dakota, Rhode Island*,
Tennessee and Wisconsin.

*Permits one plan to issue both hospital and medical service contracts.

Not all of the present medical or combined hospital and medical plans are organized under this legislation. Five plans (Cleveland, Nebraska, Oklahoma, Sacramento, and Texas) are organized as mutual insurance companies in compliance with the state laws regulating such organizations. Five plans (California Physicians' Service^{2/}, and the Colorado, Delaware and the two

* As of May 1946.

1/ Appendix G contains the text of a model law of this type, drawn up by the Blue Cross Commission.

2/ The Insurance Commissioner of California began an action in 1940 against California Physicians' Service on the ground that it was illegally engaging in the insurance business. The District Court of Appeal in February 1945 handed down a decision to the effect that CPS is not in the insurance business but is a service organization in the nature of a cooperative.

Missouri plans) and the numerous county medical society plans in Washington^{3/} have been considered or consider themselves as not engaging in the insurance business and operate without special enabling legislation. The plans in New Orleans and Oregon operate under legislation designed to permit the operation of "service insurance" companies and "hospital associations", respectively.^{4/}

RELATIONSHIP OF MEDICAL AND HOSPITAL PREPAYMENT

Of the 26 laws providing for medical prepayment by non-profit plans, the acts of 17 States provide for medical service plans separate and distinct from hospital plans.^{5/} In these States medical and hospital plans must be organized as separate corporations.^{6/}

The acts of the other nine States make it possible for one and the same plan to offer both hospital and medical prepayment. The laws of Arizona, Florida, North Carolina and Virginia^{7/} authorize the establishment of separate hospital and/or medical plans or of combined plans. The Maryland law provides for health service plans which may offer either hospital, medical or dental service or any combination of these services. The Alabama and Maine acts authorize hospital service plans to offer both hospital and medical service. The Rhode Island law provides for non-profit medical service corporations, but also specifies that a corporation organized under the hospital service plan act may, with the consent of the State medical society, amend its articles of association, and may then exercise the powers of a non-profit medical service corporation. The California Act is of a different nature from the others in that it was not intended to provide for general medical prepayment. The legislation, passed as an amendment to the hospital service plan act, was designed to permit hospital service plans to cover x-ray, pathology and similar medical services in the hospital. The act permits hospital service plans to offer "indemnification of the beneficiary or subscriber for the costs and expense of professional medical service rendered during hospitalization", and under this wording the Oakland and Sacramento plans have offered indemnification for the cost of physicians' service in the hospital.

PROVISIONS OF ENABLING LEGISLATION FOR MEDICAL SERVICE PLANS

This review of the provisions of enabling legislation for medical service plans will not deal with those acts which permit combined hospital and medical plans, since the provisions of these laws, except for the sections

^{3/} The Attorney General of the State of Washington has questioned the legal status of the county medical service plans but as yet no adverse determination of their legal status has been made.

^{4/} See Chapter 7.

^{5/} Connecticut, Illinois, Iowa, Kansas, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Tennessee, Vermont, West Virginia and Wisconsin.

^{6/} There is nothing in the acts of any of these States which would prevent some interlocking of the directorates of medical and hospital plans -- indeed in most States it would be legally possible for the directors of the two corporations to be the same people. However, in many States the hospital or medical plan act contains provisions, such as that a majority of the board of directors must be hospital representatives or physicians, which would constitute a practical barrier to the two corporations having identical directorates.

^{7/} The Virginia act is so verbose, unnecessarily complicated and in part contradictory that it is hard to tell what it means. It certainly seems to provide that one plan may offer both hospitalization and medical services in the hospital, and it is believed to provide that one plan may offer both hospitalization and medical service in or out of the hospital.

(AS OF MAY 1, 1946)

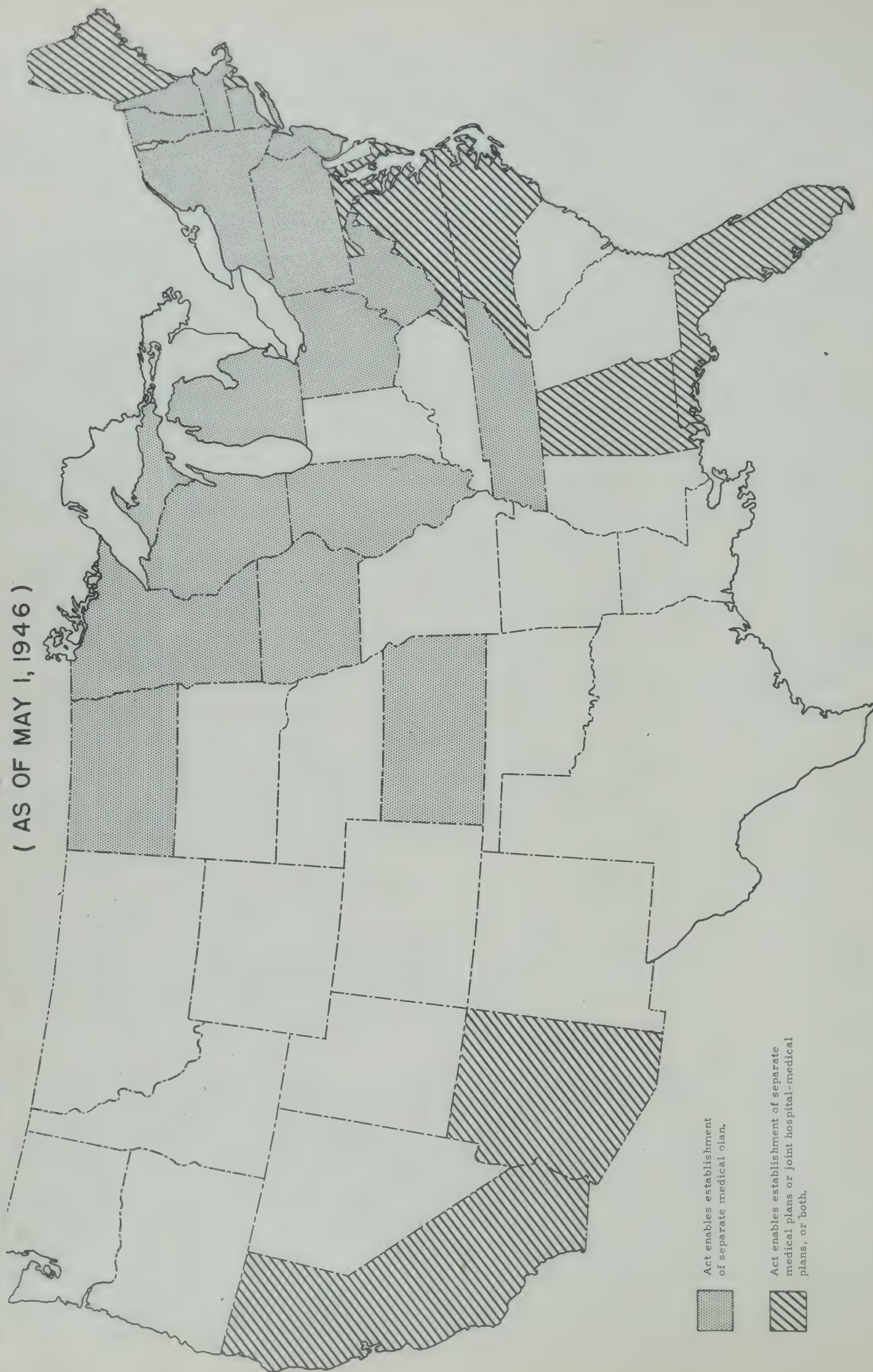


FIGURE 14

relating to participating physicians and underwriting by physicians, were described in the chapter dealing with the legal status of hospital plans. This review, therefore, will concern itself solely with the provisions of the 17 acts providing for separate medical plans and the sections of the acts providing for combined plans which were not previously dealt with.

In general the acts providing for medical service plans resemble quite closely the hospital service plan act of the same State, except for those provisions relating particularly to medical service. All provide for the organization of such plans, state that these shall be subject to the provisions of the act in question and exempt them from all provisions of the insurance code, except as otherwise designated. All provide for some degree of regulation by the State insurance department. Except in a few states,^{8/} the plans are exempted from state and local taxes (except in some cases state or local taxes on real estate).

BOARD OF DIRECTORS.

Control over medical service plans is definitely given to the medical profession in most of the 17 acts providing for separate medical plans. Six acts stipulate that a majority of the Board of Directors shall be physicians.^{9/} In one State^{10/} all the directors, and in three States^{11/} a majority of the directors must be approved by the State medical society or the officers thereof. Two acts^{12/} do not mention the composition of the board but provide that all the incorporators must be physicians, which means that initially, at any rate, the profession may determine the composition of the board. The Wisconsin act provides that only State or local medical societies may establish plans.

The Kansas act contains a provision which is worth noting. It provides that the Governor of the State shall appoint two members of the public to the board.

PRACTITIONERS ELIGIBLE TO PARTICIPATE

Of the 26 acts about half stipulate that the plan may extend the privilege of participation to, or may offer the services of, doctors of medicine only. Some other acts state only that participation is limited to duly licensed physicians, which may be interpreted to include osteopaths in a few of these States. In Iowa a medical plan may contract with "physicians and surgeons, osteopathic physicians or osteopathic physicians and surgeons." The Wisconsin law states that the insured shall be free to choose any medical or osteopathic physician who has agreed to abide by the plan according to its terms. The New York act states that "every such plan shall be open to the participation of duly licensed physicians without discrimination against schools of medical practice defined in the education law." There is a similar provision in the Maine law.

In Maryland and Vermont dentists may be included in a medical plan, or they may participate in independent plans. In Vermont osteopaths (and other types of limited practitioners as well) may organize their own plan. A number of the acts permit the plans to offer nursing services.

The Minnesota act does not permit a medical service plan to contract with any physician for the provision of service to a subscriber. Thus, a plan in this State can operate only on an indemnity basis.

^{8/} Iowa and Tennessee. The situation in a few other States is not clear.

^{9/} Illinois, Iowa, North Dakota, Pennsylvania, Tennessee and West Virginia.

^{10/} New Jersey.

^{11/} Massachusetts, Michigan and New Hampshire.

^{12/} Minnesota and Vermont.

The laws of a number of States (Illinois, Massachusetts, North Dakota, Pennsylvania, Tennessee and possibly others) specifically state that every licensed physician or every licensed physician in good standing shall have the right to participate.

The Pennsylvania law is of interest in that it is the only one which specifies how a medical plan may refuse participation to a licensed doctor of medicine. It is stated that the corporation, with the approval of the State Department of Health, may refuse to place the name of any doctor of medicine on its register. A physician on the register may be removed, again subject to the health department's approval.

UNDERWRITING BY PHYSICIANS

Only 7 of the 26 acts mention this subject. In six States the law requires the plan to be underwritten by its participating physicians.^{13/} On the other hand, the Tennessee act provides that "such contracts (with subscribers) shall make clear that the responsibility for service rests with the Corporation and not with the participating physician."

SUPERVISION BY THE STATE INSURANCE DEPARTMENT

In general, there is great similarity between the hospital and medical service acts in this respect. All of the 17 acts providing for separate medical service plans provide for some supervision by the State insurance department, except that in Wisconsin the degree of supervision is so slight as to be almost non-existent. Except in Wisconsin, all plans must submit annual reports, and visitation and examination by the department is either compulsory or at the department's discretion. Except in Wisconsin, all plans must obtain a license from the insurance commissioner before commencement of business. In Pennsylvania the health department must approve before a license can be issued by the insurance department. Except in North Dakota and Wisconsin all subscriber contracts, including the rates to be charged, must be approved by the insurance commissioner. In Wisconsin the insurance commissioner approves the form of the contracts only. The acts of three States give the insurance commissioner supervision over rates of payment to physicians.^{14/} Where the plans issue indemnity contracts the insurance Commissioner has some control over the payments to physicians since the indemnity fee schedule is part of the subscriber contract. The provisions regarding reserves and administration and acquisition costs are for the most part of the same general nature as those of the hospital plans and need not here be described.

OTHER PROVISIONS

The Ohio law provides that no medical service plan shall issue a contract to a single or married person with incomes during the preceding six months of more than \$900 or \$1200, respectively. This provision has made it impracticable to organize plans in this State under the enabling legislation.

^{13/} Arizona, Florida, Kansas, Maryland, Virginia and West Virginia.

^{14/} Massachusetts, Pennsylvania and Tennessee.

CHAPTER 19

THE CONTROL OF MEDICAL PLANS

In discussing the control of medical plans, a sharp distinction must be made between those plans which are organized as separate corporations with their own boards of directors and those plans wherein both medical and hospital prepayment contracts are offered by a single corporation with one board of directors.

There are nine plans of the latter type.^{1/} The method of selection of the boards of directors of these plans has been discussed in Chapter 8. It suffices to say here that in most cases the boards are so selected as to give representation to the hospitals, the medical profession and the public.

In the great majority of the separate medical plans the by-laws of the plan fix control definitely and firmly in the medical profession.

Some typical arrangements are as follows:

The board of directors of California Physicians' Service consists of 12 persons all of whom are elected by the House of Delegates of the California Medical Society.

The Michigan plan has a board of 24 members. Board members are elected by the voting members of the corporation who consist of all members of the House of Delegates of the Michigan Medical Society, the board members themselves and others elected by the board. The by-laws stipulate that at least two-thirds of the directors must be doctors of medicine.

Board members of the Massachusetts plan (15 in number) are elected by the voting members of the corporation, all of whom are named by the State medical society.

The New York City plan (United Medical Service) has a board of 24 members. Board members are elected by the voting members of the corporation who consist of the presidents of the 17 county medical societies, the president of the State society, the president of the New York Academy of Medicine and the board members themselves. A majority of the directors must be physicians.

In the Utica plan the incorporators elect the first board which from then on is self-perpetuating. A majority of the directors must be physicians.

The Cleveland plan is organized as a mutual insurance company. Each subscriber has one vote at any annual meeting for the election of trustees, but the votes of absent members are cast, through a system of automatic proxies, by the existing trustees, so that in effect the board of trustees is self-perpetuating.

In general the plans fall into three groups with respect to the method of selection of the boards of directors.

(a) *The boards of directors are elected by the house of delegates or board of trustees of the state or local medical society, or by the participating physicians of the plan, or by the voting members of the corporation, all or a majority of whom are elected by the state or local medical society.*

^{1/} Alabama, Oakland, Sacramento, Delaware, New Orleans, Chapel Hill, Durham, Northwest Hospital Service of Oregon and Huntington.

The majority of the plans (16 of the 26 plans which were in existence in February 1946) are in this category.^{2/} Most of these plans stipulate that a majority of the directors must be physicians.

(b) The boards of directors are self-perpetuating or are elected by the voting members of the corporation who in turn are named by the board of directors, or by the board of directors and the medical society jointly, the society naming not more than half.

Six (out of 26) of the plans are in this category.^{3/} In three of these plans^{4/} there are provisions which would assure the profession a dominant voice in conducting the plan. One plan provides that a majority of the directors must be approved by the medical society, another that one-half of the directors must be physicians, a third that two-thirds of the directors must be physicians.

(c) The plan is organized as a mutual insurance company, and the directors are elected by majority vote of the subscribers at an annual meeting.

Four (out of 26) plans are in this group.^{5/} In theory these plans are controlled by their subscribers. In practice the boards of directors are self perpetuating. Few subscribers will attend the annual meeting and the existing board can always obtain sufficient proxies to secure election of the desired individuals. Some of these plans have provisions which assure this result. Those of the Cleveland plan have already been indicated. Under the Nebraska plan no notice of the annual meeting need be given subscribers. Two of these plans have stipulations which assure medical control. The Oklahoma plan requires that nine of the 15 directors shall be physicians. The articles of incorporation of the Nebraska plan stipulate that six of the nine directors shall be members of the state medical association.

THE COMPOSITION OF THE BOARDS OF DIRECTORS

The following table shows the composition of the boards of the various plans.

It is evident that the boards of the separate medical plans are composed very largely of physicians. In only four of the separate medical plans are physicians not in a majority. In seven of these plans there is not a lay person on the board. This situation has its reverse counterpart in Cleveland, where the plan does not have a physician on its board. The joint hospital and medical plans, as might be expected, present a different picture. Here the physicians tend to be a minority.

The dominant position held by physicians in the control of nearly all of the separate medical plans is modified or tempered to a certain extent by two factors. One factor is that almost all of these plans are administered and offered to the public by the hospital plan with which it is allied. Joint offering of the two plans requires dovetailing of some of their provisions, as for instance waiting periods, enrollment policies, promotion methods, etc.

^{2/} California Physicians' Service, Iowa, Kansas, Massachusetts, Michigan, Kansas City, New Jersey, Buffalo, New York City, Syracuse, Ohio Medical Indemnity (directors elected by shareholders), Oregon, Pennsylvania, Richmond, Washington, Charleston (probably). This classification is based on data as of late 1945 or early 1946 and it includes only the plans which were in existence in February 1946.

^{3/} Colorado, St. Louis, Utica, New Hampshire and Medical Service Ass'n. of Durham, Roanoke (probably in this group). See note 2.

^{4/} New Hampshire, St. Louis and Utica. See note 2.

^{5/} Nebraska, Cleveland, Oklahoma and Texas. See note 2.

TABLE 31

Composition of Boards of Directors of Medical Plans
 (Data as of late 1945 or early 1946 unless otherwise indicated)

PLAN	TOTAL NUMBER OF DIRECTORS	NUMBER OF DOCTORS OF MEDICINE	NUMBER OF OTHER PERSONS
SEPARATE MEDICAL PLANS			
CALIFORNIA PHYSICIANS' SERVICE ^{1/}	12	10	2
COLORADO	14	8	6
FLORIDA	<u>2/</u>	<u>2/</u>	<u>2/</u>
INDIANA	<u>2/</u>	<u>2/</u>	<u>2/</u>
IOWA	17	11	6
KANSAS	19	16	3
LOUISIANA PHYSICIANS SERVICE ^{1/}	11	10	1 ^{3/}
MASSACHUSETTS	15	5	10
MICHIGAN	24	17	7
KANSAS CITY	ALL FIFTEEN DIRECTORS ARE PHYSICIANS		
ST. LOUIS	20	15	5
MONTANA ^{1/}	ALL NINE DIRECTORS ARE PHYSICIANS		
NEBRASKA	9	6	3
NEW HAMPSHIRE	17	8	9
NEW JERSEY	8	7	1
NEW MEXICO ^{1/}	ALL ELEVEN DIRECTORS ARE PHYSICIANS		
BUFFALO	24	16	8
NEW YORK CITY	24	13	11
ROCHESTER ^{1/}	22	14	8
SYRACUSE	24	15	9
UTICA	23	13	10 ^{4/}
MEDICAL SERVICE ASS'N., DURHAM	11	6	5
NORTH DAKOTA	<u>2/</u>	<u>2/</u>	<u>2/</u>
CLEVELAND	21	0	21
OHIO MEDICAL INDEMNITY	21	13	8
OKLAHOMA	15	9	6
OREGON	ALL DIRECTORS ARE PHYSICIANS		
PENNSYLVANIA	11	9	2
TEXAS	28	9	19
UTAH ^{1/}	ALL NINE DIRECTORS ARE PHYSICIANS ^{6/}		
RICHMOND	27	20	7
ROANOKE	9	6	3
WASHINGTON (KING COUNTY)	ALL DIRECTORS ARE PHYSICIANS		
CHARLESTON	ALL TEN DIRECTORS ARE PHYSICIANS		
MILWAUKEE	<u>2/</u>	<u>2/</u>	<u>2/</u>
JOINT HOSPITAL AND MEDICAL PLANS			
ALABAMA	59	38 ^{5/}	21
OAKLAND	9	5	4
SACRAMENTO	7	2	5
DELAWARE	16	4	12
NEW ORLEANS	22	3	19
CHAPEL HILL	12	4	8
HOSPITAL CARE ASS'N., DURHAM	5	0	5
NORTHWEST HOSPITAL SERVICE (OREGON) ^{1/}	14	3	11
HUNTINGTON	13	5	8

^{1/}Data as of late 1946 or early 1947.

^{2/}Information not obtained.

^{3/}This lay member is the executive director.

^{4/}Includes one osteopathic physician.

^{5/}Most of these are owners or administrators of hospitals.

^{6/}Seven of the nine are known to be physicians and it is believed that the other two are also.

Further the hospital plan might conceivably refuse to offer a medical plan which it thought to be unsound or unattractive to the public. Therefore, in a measure the hospital plan may be said to exercise, at least potentially, some degree of control relative to the medical plan. The second factor is that almost all of these plans are administered by the lay person who administers the hospital plan. In the last analysis, as was pointed out in the discussion of the control of hospital plans, this person's success and job depends upon public acceptance of the plans. Therefore, his influence upon the control of the two plans, which is considerable, will tend to be thrown towards making the plans as attractive to the public as possible.

SOME OBSERVATIONS ON THE CONTROL OF MEDICAL PLANS

What should be the composition of the boards of medical plans? Should these plans be controlled entirely by the medical profession, entirely by the public, or should both parties share in the control, and if so in what proportions?

The answer would seem to depend in great part upon what is considered to be the nature and purpose of these organizations.

The plans might be viewed as having the nature of producers' cooperatives, organizations owned by the profession and operated for the profession's advantage and benefit, with participating physicians taking both the gains of the enterprise and the risk of loss. If this is the real nature of the plans then it would seem that exclusive control should lie with the medical profession, and there is no reason why there should be any public representation whatever. Only in Washington and possibly in Oregon do the plans formally have this character, though undoubtedly this conception of the possible nature of the plans has influenced the thinking of physicians elsewhere.

Generally the plans have been presented to the public as non-profit organizations operated primarily for the benefit of the public. If this is the purpose of the plans, then it would seem that some representation on the boards of the plans should be given to those whom the plans are designed to serve.

Assuming that both the medical profession and the public should be represented on the boards, then the relative share of the two groups in the control of the plans would be affected, among other factors, by which group underwrites the plan. If the profession underwrites the plan then clearly its share in the control of the plan should be greater than if no such obligation is undertaken. Indeed it might well be argued that where the plan is underwritten exclusively by the profession, then the profession ought to have majority control, for why should the physicians assume the risk of loss unless they are in a position to see that losses do not occur.

In Chapter 17 the conclusion was reached that it was important that a new plan (unless from the outset it is provided with sufficient capital funds to assure that it will be able to meet its contractual obligations to subscribers) should be underwritten by the profession. However, as a plan accumulates reserves then these reserves also serve to guarantee the plan's contracts. The plan's reserves belong to the public. Hence as a plan gains adequate reserves and begins to stand on its own financial legs, then even though the profession continues to underwrite the plan contractually, in reality the underwriting burden is shared between the public and the profession. When this state is reached, it is not so clear that the profession should have majority control. Indeed, given the purpose of the plan -- to

serve the public -- it would seem that under these conditions majority control should lie with the public.

Everywhere the medical profession has more or less instinctively assumed that it should control these plans. The reasoning of physicians which leads them to this conclusion is based less on the above mentioned factors than on the feeling that the plan is a *medical* plan, that physicians are the only ones who have any competence in medical matters and that accordingly the profession should control.

It is suggested that in this reasoning the profession confuses two things -- the practice of medicine and medical economics. Only physicians are competent to provide medical service, but the questions of how medical services shall be paid for and at what rates are ones on which the public should have as much, if not more, say than the profession.

Control of the plans carries with it the determination of what fees or remuneration shall be paid to physicians for their services. If the whole population were enrolled then control of the plans would carry with it determination of the incomes of the profession. Physicians would hardly maintain that this is something on which only they should have a voice.^{6/} In the last analysis it is the public which will determine what it will pay for medical service. On this basis, it would seem that control of the plans should lie with the public and that the fees to be paid by the plans should be arrived at by negotiation between the plan and the organized medical profession.^{7/}

The considerations presented above are largely of a theoretical nature, which, however, should not diminish their importance. During the course of the survey it was observed that in practice overwhelming medical domination of the plans is often prejudicial to their success. Most medical plans need a greater degree of lay representation on their board for two reasons.

First, the plans need to obtain the point of view of the subscribing public. Physicians tend to see medical economic questions from one point of view; the public from another. Where the plan's board is entirely or almost entirely made up of physicians, the board may pursue unwise policies because it is uninformed as to what the reaction of the subscribing public is or will be. The plans are for the public and they need representatives of the public on their boards so that they may be responsive to the needs of the subscribing public.

6/ A non-profit plan which is controlled by persons engaged in the practice of medicine for profit seems to be a contradiction in terms.

7/ Physicians commonly assume that they set their own fees. Actually of course they do not; fees are determined by the interplay of supply and demand forces. The average physician must charge at the market rate for his services if he wishes to have patients. The following extract from a speech by John Hunton, Executive Secretary of California Medical Ass'n., indicates the situation:

".....A few years ago at one of our meetings I happened to be in a conversation with two gynecologists, and one of them was talking about the fees that he charged. The other said 'Who sets your fees?'"

"I set my own fees."

"What do you mean, you set your own fee?"

"Why I tell every patient what my fee is going to be, and that is what it is."

"Wait a minute! You don't set your own fee. A woman comes to you and you examine her and you say she should have a certain piece of surgery performed. She says 'How much will it cost me?' You say it will be \$200, and she replies 'I want to talk it over with my husband.' The next week you see her in a hospital and somebody else is operating on her, and he doesn't charge the high fee that you do. Or she comes in and you say 'My fee is \$200.' You operate on her and send her a bill for \$200, and she pays you \$100. Who sets your fee? The public sets your fee -- your patients set your fee. You are not doing it yourself at all." (*The Journal of the American Medical Association* - Feb. 23, 1946, pg. 515.)

Secondly, in the long run the success of medical plans, as well as hospital plans, depends upon the extent to which these are identified with the community and become looked upon as community organizations. If the plans are to have a full measure of success the public must feel that the plan belongs to the public, that it is their plan. People will not feel that the plan is for the public's benefit -- that it is a community organization -- when 100 or 80 percent of the board members are physicians. In short the plan cannot be successfully presented as a public plan, unless the public has a fair share in its control -- unless it really belongs to the public.

THE SELECTION OF PUBLIC REPRESENTATIVES

The selection of public representatives on the boards of the plans raises difficult problems. The medical members can be elected by the State or local medical society, or appointed by the governing body of the society. If the public representatives are also elected or appointed by the medical society, or are elected by the remainder of the board, a majority of whom are physicians, then it may well be that no proper representation of the public will be provided for. Election of the lay members by the subscribers at an annual meeting does not work.^{8/} Use of this device means that the board as a whole or its lay members are self-perpetuating.

Then how shall the lay members of the board be selected? Perhaps the lay members could be appointed or selected by the board as a whole, but under formal or informal provisions which would require that persons should be selected who would be endorsed or nominated by significant public groups, e. g., the State or local council of labor organizations, an organization of farm groups, a State or local organization of employers, an organization of social agencies. A provision that the health officer of the State or (if the plan is a local one) of the principal city in the plan's area should always be a member of the board might help to secure representation of the public's interests. Use of devices of this sort might well result in a board which would in fact give representation to the various parties at interest.

In the final analysis perhaps the best and most democratic method of selection of the lay members of the board would be to have them appointed by the Governor of the State or (if the plan is a local one) the mayor or council of the principal city of the area. This is done in Kansas where the enabling law requires that two members of the board shall be appointed by the Governor.

^{8/} See Chapter 8.

CHAPTER 20

ADMINISTRATION OF MEDICAL PLANS; FINANCES; CANCELLATIONS; UTILIZATION; NATIONAL COORDINATION

ADMINISTRATION

Many of the functions involved in the administration of medical plans are of the same character as those performed under a hospital plan. This is true of enrollment, billing, and maintenance of subscriber records, and in integrated or allied medical and hospital plans these operations are performed jointly for both plans. When a hospital plan is expanded administratively into a hospital-medical plan the only new operations involved are direction of the medical prepayment activity as a whole, the payment of physicians (or medical claims), and the maintenance of relations with the medical profession.

When a hospital admits a subscriber it sends an admission notice to the plan to ascertain whether the latter accepts responsibility for the bill. This step is generally eliminated under the medical plans. The physician when he first accepts a case can if he wishes send in an initial service report to the plan to ascertain the patient's eligibility, but most physicians do not do this. The physician assumes from the patient's statement or identification card that he is a member in good standing, performs the service, and after the patient's discharge from the hospital or at the end of the month, sends in to the plan a bill or report of service. This gives the patient's name and other identifying information, the diagnosis, the date on which service was performed, the nature of the service or services performed, etc.

The plan checks this against its subscriber records to ascertain if the recipient of service is a subscriber and is paid up. A record of the service performed and the physician performing it is then entered on the subscriber's record or claim card. Some plans maintain these cards separately from the hospital record card; in other plans they are attached to the card showing hospital service received, or the same card is used for both.

After the amount due the physician is determined, a punched card is prepared for accounting and statistical purposes. These cards are later run to prepare the voucher for each physician and the check.

Most of the larger plans have a full or part time medical director who aids in the interpretation of the physician's bill or report of service in instances where there is question as to just what service was performed and what amount is payable. This physician frequently tends to become the point of contact between individual physicians and the plan.

Most of the plans have a medical review or advisory committee appointed by the medical society. This committee will review cases in which there is some question as to the fee to be paid, for example where a physician claims that he should be paid more than the standard fee for an operation because of the unusual nature of the case, complications, etc. By virtue of consideration of many such cases the committee is able fairly to appraise the diffi-

culties or complications in a case and set a fair fee. The committee's decision as to the fee to be paid is generally accepted without demurrer, whereas a decision by the medical director might not be so accepted. In any case appeals from the medical director's decision can be made to the committee. Some plans state that the role of such a committee is a vital one.

Virtually all medical plans, whether allied with a hospital plan or not, have lay executive directors. The only exception, to the writer's knowledge, is the New Jersey plan. California had a physician as executive director for some years and replaced him with a lay administrator. Most of the functions performed in administration of a plan are of a business or insurance character, and the administrative talent required is more apt to be found among lay persons than among physicians. The lay administrator delegates to the medical director those functions requiring medical knowledge.

In plans providing office and home calls, controls are necessary to protect the plan against bills for unnecessary services. The controls (which go beyond office and home calls) utilized by the King County Medical Service Bureau in Washington, may be cited as an example. This plan will not pay for an operation, except in emergency cases, unless there was prior consultation and the physician consulted agreed to the necessity of the operation. Tonsil and hernia cases will not be paid for unless the plan's medical director has himself examined the patient. In cases where the physician desires to recommend extensive laboratory and x-ray work, he must receive the medical director's approval before ordering these tests.

The medical director routinely inspects all bills and cuts down those wherein in his opinion an excessive number of calls have been made. For instance the physician may have billed for five home calls; the medical director may judge that the case should have been handled with three calls and will allow payment accordingly. The bills of most physicians are not "adjusted". But there are a few physicians who tend to "chisel" or who in all good faith routinely make more calls per case than do most physicians. The decisions of the medical director are rarely questioned. He has the confidence of the local profession.

It is probable that controls of this character would be required under any plan covering home and office services.

FINANCES

Table 32 gives the salient financial data on the operation of medical plans. Data are presented only for those plans which were in operation during the full year of 1945;^{1/} data for plans with less than a full year of operation are generally not significant for the purposes in hand.

The present medical plans, as these data tend to show, have been run on two different principles. A few of them -- Oregon Physicians' Service, the plans in the State of Washington (for which data are not available), and California Physicians' Service -- are operated on a theory which holds that the plans have no or little need of reserves.^{2/} These plans depend on the prorating of payments to physicians as a necessary and customary part of their functioning. The plans in Washington, Oregon and California (the latter in

^{1/} Data were not obtained from a few plans.

^{2/} CPS would like to accumulate reserves and stop *prorata* reduction of payments, but thus far it has been unable to do so.

TABLE 32

Finances of Medical Plans, 1945

PLAN	NUMBER OF PARTICIPANTS DEC. 31, 1945	TOTAL INCOME 1945	PHYSICIAN EXPENSE		ADMINISTRATIVE EXPENSE		ADDITIONS TO RE- SERVE (OR DEFICIT)		RESERVES DEC. 31, 1945	RESERVES PER PARTICIPANT DEC. 31, 1945
			AMOUNT	PER- CENT	AMOUNT	PER- CENT	AMOUNT	PER- CENT		
SEPARATE MEDICAL PLANS		\$			\$		\$		\$	
MICHIGAN	858,235	5,420,351	4,298,285	79.3	620,908 ^{a/}	11.5	501,158	9.2	695,175	.81
MASSACHUSETTS	221,845	1,112,165	649,083	58.4	159,200	14.3	303,882	27.3	406,308	1.83
CALIFORNIA PHYS. SERV.	169,810	1,655,874 ^{b/}	1,436,380 ^{b/}	86.7	365,317	22.1	-145,823	-8.8	0	0
NEW YORK CITY	159,473	738,457	434,826	58.9	95,430	12.9	208,201	28.2	241,133	1.51
COLORADO	95,362	435,871 ^{c/}	384,842	88.3	41,045	9.4	9,984	2.3	24,691 ^{c/}	.26 ^{c/}
OREGON	85,000	911,353 ^{d/}	781,181 ^{d/}	85.7	124,686	13.7	5,486	.6	39,476 ^{d/}	.46 ^{d/}
BUFFALO	61,813	490,311	447,932	91.3	67,991	13.9	-25,612	-5.2	-14,058	-.23
KANSAS CITY	51,746	320,008	240,284	75.1	46,315	14.5	33,409	10.4	90,567	1.83
NEW JERSEY	49,441	327,112	208,288	63.7	57,057	17.4	61,767	18.9	61,457	1.67
UTICA	44,695	149,707	61,009	40.8	22,910	15.3	65,788	43.9	18,427	1.02
NEW HAMPSHIRE	36,863	101,346	70,804	69.9	10,142	10.0	20,400 ^{f/}	20.1	23,558	4.22
CHARLESTON	18,075	22,513	6,688	29.7	10,052	44.6	5,773 ^{f/}	25.7		
NEBRASKA	5,579									
TOTAL	1,857,937	11,685,068	9,019,602	77.2	1,621,053	13.9	1,044,413	8.9	1,586,734	.90 ^{1/}
COMBINED HOSPITAL- MEDICAL PLANS										
DELAWARE	69,518 ^{g/}	350,774 ^{g/}	247,442 ^{g/}	70.6	42,503	12.1	60,829 ^{g/}	17.3	116,506 ^{g/}	1.68
CHAPEL HILL	110,907 ^{h/}	227,150 ^{g/}	144,332 ^{g/}	71.3 ^{h/}	36,923	16.3	45,895 ^{g/}	20.2		
OAKLAND	56,143 ^{g/}			63.5						

a/ Includes contribution of \$10,000 to Michigan Fund for Medical and Health Education.

b/ For the fiscal year ending March 31, 1945. Data include income and expense from hospital contracts.

c/ For the period 5/1/45 to 2/28/46. Reserves as of Feb. 28, 1946.

d/ For the first six months of 1945. Reserves as of June 30, 1945. "Physician expense" includes expense for hospitalization, dental services, nursing, first aid services, etc.

e/ Information not obtained.

f/ Excess of income over expenditures, i.e., no allowance having been made for claims incurred but not reported.

g/ Medical contracts only.

h/ Ratio of surgical claims to surgical income.

i/ Participants in the Kansas City and Utica plans excluded in computing this figure.

j/ Plan does not maintain separate reserve for medical contracts.

the northern part of the State where it has hospital contracts outstanding) pay hospitals, and other providers of service, except physicians, at the scheduled rates. Then if the amounts remaining over and above administrative costs are insufficient to pay physicians at the scheduled rates, payments to the latter are reduced *pro rata*.

This type of arrangement has the advantage that the plan can use all income, except that necessary for administration, to provide benefits to subscribers. It has the great disadvantage that many physicians do not like it. Physicians having rendered service cannot count on receiving any set amount. What they will receive will depend upon the value of the "unit" for that month.

The remaining plans are run on the same basis as the hospital plans. These plans aim to accumulate a reserve to carry them over any temporary period of unfavorable experience and to give them a chance to adjust subscription rates or fee schedules so as to regain a sound financial position. Some of these plans are underwritten by their participating physicians, but the obligation of these physicians to accept reduced payments, if necessary, is looked upon as a secondary line of defense. The plan is glad to have it, but it is operated in such a way as to obviate the need for drawing upon it. The reserve constitutes the first line of defense against adverse experience.

Aside from two or three plans which tend to operate without reserves, the general picture presented by these data is very much the same as in the case of the hospital plans. In the aggregate the plans used 77.2 percent of total income for payment of physicians' fees, 13.9 percent for administration, and 8.9 percent for additions to reserves. (These figures are powerfully weighted by Michigan Medical Service the income of which almost equals that of all the other plans together.)

As compared with the hospital plans, the medical plans seem to show relatively greater variation in the proportion of income used for benefits. This is understandable in the light of the newness of the medical plans and the fact that they are feeling their way, as it were. Some of the plans, the Massachusetts, New York City and New Hampshire plans for example, have pursued a very conservative financial policy; they have wanted to gain experience and to build up a good reserve before liberalizing benefits. In Massachusetts the insurance department, mindful of Michigan's early experience, has forced the plan to pursue a very conservative policy.

Thus far the administrative costs of the medical plans run higher, on the average, than those of the hospital plans. One reason for this is the expense which new medical plans are under to "educate" the profession in their area, to explain the plan to county medical societies, etc., and to persuade physicians to participate. The activities which must be undertaken in this regard are far more extensive than those which a new hospital plan must undertake to win the participation of a limited number of hospitals.

Whether in the long run it will cost more, in terms of percent of income, to administer medical than hospital prepayment, it is difficult to say. Many plan directors think that it will. They base this conclusion on the fact that in processing a hospital bill there is only the one item to be dealt with and the one payment to be made, whereas in a surgical case, for example, there may be bills from three or four physicians for the same case--the surgeon, the assistant, the anesthetist and the radiologist. These plan directors also point out that it costs about the same amount to process a claim whether the amount of the claim be small or large, and that the average

claim will be smaller under medical than under hospital prepayment. By the same reasoning it is concluded that the administrative costs under a medical plan providing comprehensive service, wherein there would be a great multitude of small claims or bills to be paid, would be relatively high. Be this as it may, it may be noted that Oregon Physicians' Service and Buffalo, both of which provided relatively comprehensive service, were administered in 1945 for 13.7 and 13.9 percent of income respectively. The plans in the State of Washington, which provide a comprehensive service are said to have administrative costs of seven to eight percent of income.^{3/} Officials of King County Medical Bureau (Seattle) stated that in 1944 their administrative costs were only 6.04 percent of income.

The combined hospital-medical plans, such as Delaware, keep track of income and benefit expense for hospital and medical contracts separately. (Some of them do not report this breakdown in their annual financial reports.) None of these plans, however, make any effort to go into the cost accounting procedures which would be necessary to determine administrative costs separately for the two types of contracts. In calculating the financial status of each type of contract these plans simply apportion their total administrative costs between hospital and medical prepayment on the basis of the income derived from each.

Only one of the combined hospital-medical plans -- Delaware -- sets up a separate bookkeeping reserve for its medical contracts. The other plans simply have the one reserve for both contracts. In all of these plans, Delaware included, from a legal standpoint the plan's total reserve is equally available to back up hospital and medical contracts.

For all of the separate medical plans together, the amount of reserves per participant at the end of 1945 was \$.90. This varied among the plans from a minus figure in the case of the Buffalo plan to \$1.83 in the case of the Massachusetts and New Jersey plans.

Some comment upon the showing of a few of the plans is in order. The Buffalo plan had experienced a much greater demand for its comprehensive contract covering physicians' services in the home, office and hospital than for the limited surgical contract. However, over the years the number of services utilized per subscriber under the comprehensive contract steadily increased -- the increase in 1945 being such as to result in a substantial deficit for the plan. As a result in January 1946 the plan discontinued further sale of this contract. The experience indicates the lack of settled actuarial knowledge of utilization to be expected under contracts covering home and office calls.

California Physicians' Service began to have an unfavorable financial experience in the early summer of 1944. At the time of the visit to the plan in February 1945, officials of the plan were not certain of the causes for this development. This gave the plan a substantial deficit for its fiscal year ending March 31, 1945. Despite the rate increase installed in the spring of 1945, the unfavorable experience continued and the plan was forced later in 1945 to reduce the unit from \$2.25 to \$2.00 (par is \$2.50).

The showing of the Nebraska plan is probably affected by the fact that the plan was established in November 1944 and that the initial organizational expenses are probably reflected in the 1945 statement.

^{3/} It must be borne in mind that in comprehensive plans income per subscriber is relatively high. Hence high administrative costs per subscriber are compatible with a low administrative expense ratio.

CANCELLATIONS

Data on cancellation rates have been obtained from a few plans. These are presented, along with the comparable rates for the allied hospital plans in Table 33.

<p style="text-align: center;">TABLE 33</p> <p style="text-align: center;">Annual Member Cancellation Rates in</p> <p style="text-align: center;">Allied Medical and Hospital Plans</p> <p style="text-align: center;">(Data for the year 1946 unless otherwise specified)</p>		
PLAN	MEDICAL PLAN	HOSPITAL PLAN
DELAWARE	14.3	14.2
KANSAS	1.5 ^{1/}	2.0 ^{1/}
ST. LOUIS	15.3 ^{2/}	[17.1 ^{3/} 10.3 ^{4/}
NEBRASKA	20.3	14.7
BUFFALO	21.7 ^{5/}	21.5 ^{5/}
NEW YORK CITY	29.9 ^{6/}	23.6 ^{6/}
ROANOKE	7.2	13.2
<p>^{1/}For the month of February, 1947</p> <p>^{2/}For the 20 months up to March 1947</p> <p>^{3/}For the period April 1, 1945 to March 30, 1946</p> <p>^{4/}For the period April 1, 1946 to December 31, 1946</p> <p>^{5/}Contract cancellation rates</p> <p>^{6/}These are gross not net cancellation rates, i.e., any change of contract as for example from a husband and wife to a family contract, has been counted as a cancellation. True net cancellation rates would be considerably lower. The figures are significant only as regards the relation of the hospital and medical plan rates.</p>		

These data indicate that in some plans the cancellation rates under the two types of plans are very close or identical. In other plans the medical cancellation rate exceeds the hospital cancellation rate, and in still other

plans the reverse is true.^{4/} The available data are so meagre that they hardly provide a basis for generalization.

UTILIZATION

Few of the medical plans have developed data showing utilization of services. The reason for this is the newness of the plans and the fact that as regards surgery, at any rate, neither an overall case rate or detailed case rates for the multitude of different types of operations are apt to be very meaningful or useful to the plan.

Certain data from the Michigan plan are presented below. (Table 34.)

TYPE OF SERVICE	NO. OF SERVICES	AMOUNT PAID	SERVICES % TO TOTAL	AMOUNT % TO TOTAL	SERVICES PER 1000 MEM. MOS.	COST PER 1000 MEM. MOS.	SERVICES PER 1000 MEM. YRS.	COST PER 1000 MEM. YRS.
GENERAL SURGERY	10,406	\$ 536,887.55	4.06	5.25	.46	\$ 23.88	5.56	286.61
ANESTHESIA	22,420	177,804.50	8.75	1.73	1.00	7.91	11.97	94.92
THORACIC SURGERY	950	40,475.50	.37	.39	.04	1.80	.51	21.61
ABDOMINAL SURGERY	2,566	268,837.50	1.02	2.61	.11	11.96	1.37	143.52
HERNIOTOMIES	5,681	490,688.00	2.22	4.76	.25	21.83	3.03	261.95
APPENDECTOMIES	18,551	1,439,915.60	7.24	13.98	.83	64.06	9.90	768.69
CHOLECYSTECTOMIES	2,716	336,966.75	1.06	3.27	.12	14.99	1.45	179.89
PROCTOLOGY	7,193	430,498.50	2.81	4.18	.32	19.15	3.84	229.82
UROLOGY	14,003	354,627.75	5.46	3.44	.62	15.78	7.48	189.32
GYNECOLOGY	24,746	2,340,386.90	9.66	22.94	1.10	104.12	13.21	1,249.40
DELIVERIES	32,167	1,353,792.60	12.56	12.92	1.43	60.22	17.17	722.72
OPHTHALMOLOGY	1,554	102,676.00	.61	1.00	.07	4.57	.83	54.81
OTOLOGY	713	51,950.00	.28	.51	.03	2.31	.38	27.73
NOSE AND THROAT	3,503	174,586.75	1.36	1.69	.16	7.77	1.87	93.20
TONSILLECTOMIES	45,731	1,155,396.75	17.86	11.22	2.04	51.40	24.41	616.80
NEURO-SURGERY	1,045	65,102.50	.41	.63	.05	2.90	.56	34.76
BONE, JOINT AND TENDON	8,378	405,194.00	3.27	3.93	.37	18.02	4.47	216.31
X-RAY	53,789	575,673.50	21.00	5.59	2.39	25.61	28.72	307.32
MISCELLANEOUS	7	127.50	.00	.00	.00	.01	.00	.07
	256,119	10,301,588.15	100.00	100.00	11.39	\$458.29	136.73	5,499.45

* Based on 22,478,448 member months of coverage.

These figures show that during the three years, 1943, 1944 and 1945 surgical services in the field of gynecology constituted the largest source of cost to the plan (22.9 percent of the total), followed by appendectomies

^{4/} Under all or virtually all plans the subscriber cannot obtain medical coverage without having hospital coverage. Hence if enrollment for both coverages were about the same, cancellation rates under the medical plan would always exceed cancellation rates under the hospital plan. However, in a situation where only a proportion of the hospital plan subscribers have medical coverage it is possible for cancellation rates of the hospital plan to exceed those of the medical plan.

14.0 percent), deliveries (12.9) and tonsillectomies (11.2) in the order named. Aside from x-ray service, tonsillectomies constitute the most frequent type of case, constituting 17.9 percent of all cases.

Table 35 presents similar data from the Delaware plan.

TABLE 35						
Distribution of Cases and Costs by Type of Procedure, The Delaware Plan, May 1943 - July 1946						
(Procedures are listed in order by percent of total paid)						
SURGICAL PROCEDURE	NUMBER CASES	% of TOTAL CASES	CASES PER 10,000 EXPOSURE YEARS	AMOUNT PAID	% OF TOTAL PAID	AMOUNT PAID PER 10,000 EXPOSURE YEARS
FEMALE GENITAL	1042	4.8	81.5	\$82878.12	14.7	\$6480.32
APPENDECTOMY	769	3.5	60.1	77091.82	13.7	6027.88
MATERNITY	1325	6.0	103.6	67089.49	11.9	5245.79
X-RAY*	6840	31.2	534.8	66556.98	11.8	5204.16
ANESTHESIA	5762	26.3	450.5	34671.67	6.2	2711.01
TONSILS AND ADENOIDS	1244	5.7	97.3	31069.91	5.5	2429.38
ABDOMEN AND INTESTINES (excludes append. and hernia)	269	1.2	21.0	29765.82	5.3	2327.42
FRACTURES	592	2.7	46.3	27255.78	4.8	2131.16
SKIN AND TISSUES	1064	4.9	83.2	22313.46	4.0	1744.71
RECTUM AND ANUS	390	1.8	30.5	16419.41	2.9	1283.85
URINARY SYSTEM	401	1.8	31.4	16074.32	2.9	1256.87
EAR, NOSE AND THROAT (excludes tonsils and adenoids)	328	1.5	25.6	15790.57	2.8	1234.68
HERNIA	164	0.7	12.8	13856.32	2.5	1083.44
REPAIR OPERATIONS	146	0.7	11.4	11242.30	2.0	879.05
EYE	208	0.9	16.3	9793.33	1.7	765.75
MALE GENITAL	276	1.3	21.6	7835.65	1.4	612.68
HEAD AND NECK	67	0.3	5.2	7580.00	1.3	592.69
BREAST	129	0.6	10.1	5479.97	1.0	428.48
ARTERIES AND VEINS (excludes trans- fusions)	111	0.5	8.7	4863.25	0.9	380.26
TRANSFUSIONS	418	1.9	32.7	6200.50	1.1	484.82
CHEST	57	0.3	4.5	3176.66	0.6	248.39
MOUTH	227	1.0	17.7	3287.98	0.6	257.09
DISLOCATIONS	39	0.2	3.0	1098.00	0.2	85.85
AMPUTATIONS	34	0.2	2.7	1309.66	0.2	102.40
MISCELLANEOUS	5	0.0	0.4	156.33	0.0	12.22
TOTAL	21907	100.0	1712.9	\$562857.30	100.0	\$44010.36
* In case of hospitalized patients the hospital plan paid 50 percent of the x-ray charges in addition to the amount listed here.						

The bulk of the services and costs are for dependents. The Michigan plan found for the period April 1, 1942 to March 31, 1944 that 31 percent of all payments by the plan were on account of services for subscribers, 69 per-

cent for services for dependents. By sex and as between adults and children the showing was as follows:

	<u>Number of Services</u>	<u>Amount Paid</u>	<u>Percent of Services</u>	<u>Percent of Amount Paid</u>
Adult Male	25,145	\$ 996,011	19.71	19.25
Adult Female	58,657	3,022,445	45.97	58.41
Male Children	24,966	614,991	19.56	11.88
Female Children	18,837	541,093	14.76	10.46
Total	127,605	\$5,174,540	100.00	100.00

The New York City plan reports the following cost of claims for the year 1946 per 1000 contracts and per 1000 subscribers:

	<u>Per 1,000 contracts</u>	<u>Per 1,000 subscribers</u>
Individual Male	\$1,984	\$1,984
Individual Female	3,119	3,119
Husband and Wife	5,730	2,883
Family	13,367	4,108
Total	\$ 6,621	\$3,550

NATIONAL COORDINATION

As previously indicated the medical plans have recently formed a central organization, Associated Medical Care Plans. This organization will perform for the medical plans about the same functions as the Blue Cross Commission performs for the hospital plans.

Any plan organization, currently in operation, which meets the standards for medical care plans of the Council on Medical Service and Public Relations of the American Medical Association is eligible for full membership. Plans in process of organization may become associate members. All legislative power resides in the full members voting in meetings. The officers of the central organization consist of a president, vice-president, treasurer and secretary (the latter office may be filled by the executive director) and nine commissioners. The first four officers are elected for one year terms. Certain of the commissioners first to be elected serve for one or two year terms, but thereafter all commissioners shall serve for three year terms. Three of the commissioners shall be members of the Council on Medical Service and Public Relations of the A.M.A. The commission has employed a full time executive director, and is housed at the headquarters of the American Medical Association.

The central organization is financed by dues paid by full members in the amount of $\frac{1}{2}$ mill per month per participant with a minimum payment of \$10.00 per month and a maximum of \$250.

The standards of acceptance of the A.M.A. are such that the seal of acceptance could presumably be given to an insurance company the policies and rates of which were approved by a State or local medical society. Because of this many medical plans formerly hesitated to affiliate. The executive di-

rector of AMCP has recently been able to give definite assurance to all medical plans that only non-profit plans would be accepted as members. As of April 1947 a large majority of the medical plans then in operation had become members or had applied for membership.

The preliminary standards of acceptance of the Council on Medical Service and Public Relations are quoted in full in Appendix J. As previously indicated, the standards are such that conceivably insurance companies might receive approval. (To date, however, approval has only been given to non-profit plans.) The standards give equal approval to cash indemnity and service plans and make no statement as to which type of plan would be preferable.

PART III

SOME PROBLEMS OF

HOSPITAL AND MEDICAL

PLANS

CHAPTER 21

SERVICE AND INDEMNITY

An important problem of hospital and medical plans is whether they should provide benefits on a service or indemnity basis.^{1/}

This problem is not really acute as regards the hospital plans; the plans are mainly on a service basis; there is wide recognition of the value of this basis; present waverings from this basis will probably lead simply to reaffirmation of the service principle and greater efforts to solve the technical problems involved.

It is otherwise as regards the medical plans. Here there is full debate as to whether the plans should be on a service or indemnity basis.

It might seem that discussion of the problem should be confined to the medical plans. Actually the main principles involved are the same for both hospital and medical prepayment and reference to the practical problems in the one field tends to clarify issues and problems in the other.

SERVICE AND INDEMNITY UNDER HOSPITAL PREPAYMENT

Hospital plans are largely, though not entirely, on a service basis. The exceptions to the service basis are: (a) some plans provide dollar allowances for certain of the special services, e.g., x-ray, and laboratory services; (b) about a quarter of the plans provide a dollar room allowance instead of care in specified accommodations; (c) insofar as subscribers take better accommodations than their contract calls for and pay the difference in room cost, an indemnity element enters in.

The subscribing public certainly wants the privilege of receiving care in better accommodations than are specified in the contract. Aside from this there is every evidence that the public wants benefits on a service basis. Only on such a basis does the subscriber have a definite and adequate protection. Dollar allowances against the cost of any special service or of the special services in general open the door to the possibility that the subscriber, in case he requires an unusual amount of one or more of the special services, may have a large hospital bill to pay.^{2/}

Similarly the provision of a dollar room allowance instead of care in specified accommodations exposes the subscriber to the possibility of a sizable hospital bill. The room allowance may cover the cost of care in ward or semi-private hospital accommodations or may fall short of it. In a time of rising prices any specified room allowance falls further and further behind hospital charges. Thus the manager of the Kansas plan (which provides

^{1/} By service basis is meant that the plan provides its benefits in the form of service; by indemnity basis that the plan provides certain dollar allowances or credits against the hospital's or physician's charge and the latter have the right of charging extra.

^{2/} For example one plan recently reported paying a hospital bill of \$2,333.10 for a 62 day hospital stay. Eighty-eight percent of the bill was for drugs and dressings. Protection limited to a moderate dollar allowance against the special services would have left this subscriber with a huge bill to pay.

a dollar room allowance) writes the member hospitals to the effect that subscribers are saying "Blue Cross goes less far year by year." (In 1943 the plan covered 85 percent of the subscriber's bill, in 1945, 80 percent and in 1946, 68 percent.)

The provision of the special services on a service basis is more important than the provision of room and board on that basis. The subscriber cannot know how much of the special services he will need, whereas with a dollar room allowance he can estimate his hospital stay, recognize that in any given accommodations he will have so much extra per day to pay, and can elect his accommodations accordingly. However, service benefits as regards both elements are necessary. Nothing else gives complete and adequate protection against the cost of essential (non-luxury) hospital service.

The provision of service benefits requires cooperation between hospitals and the plan. It requires that hospitals must agree to provide certain benefits to subscribers in return for a specified remuneration from the plan. And the plan must provide fair remuneration to hospitals -- otherwise the arrangement is untenable and breaks down.

The service basis means that hospitals give up the freedom of fixing their charges as they please, and that they accept the responsibility of providing service to the public at rates which are agreed upon between all hospitals and the plan as fair and reasonable. A voluntary hospital which refuses to accept this responsibility would seem to disregard the obligations which go with its status and purpose.

In the long run the only basis of fair remuneration of hospitals is the cost of providing the service -- either the actual cost of operating the hospital or the cost at which an efficiently operated institution can provide service of a given quality and scope. However -- and this is exceedingly important -- the ability of hospitals to accept remuneration on a cost basis from the plan will depend in large measure upon their receiving remuneration at cost for the care of charity patients and governmental charges. In other words so long as the hospital provides care free or at less than cost to some patients and must finance this care from the receipts from paying patients, then of necessity it must charge these latter more than cost. Only when the care of the indigent is recognized as a responsibility of the community as a whole -- rather than a responsibility of paying hospital patients -- can hospitals accept remuneration on a cost basis from plan subscribers and other paying patients. (Unless, of course, the amount of free care given is inconsequential or the hospital can finance free care out of income from endowments or from special gifts.)

Once cost as a basis of remuneration is departed from, then there is no firm basis of reference, and remuneration is fixed by a process of bargaining. Under such a situation the plans to protect themselves may find it necessary to provide dollar allowances against the room cost or the special services or both, or hospitals to protect themselves may insist on a basis of remuneration which leads to this result. Thus in the long run and to a very considerable extent the provision of service benefits is bound up with the assumption by the community at large of the responsibility of paying hospitals at cost for service provided to those unable to pay.

SERVICE AND INDEMNITY UNDER MEDICAL PREPAYMENT

The principles involved here are largely the same as under hospital prepayment. The practical problems while different are analogous.

There is no doubt that *other things being equal* the public would much prefer the service basis. The other things that have to be equal are that people should have free choice of physician (a service plan that offers a limited choice of physicians, particularly if it does not offer the services of the better physicians, may be less desirable than an indemnity plan); that, the service arrangement will not affect quality of service adversely; and that the subscription rates (which in effect reflect rates of remuneration to the physicians) are reasonable.

Under the service basis the subscriber has full protection; if he needs medical services covered by his contract he is entitled to them and has no bill to pay. The indemnity basis, on the other hand, gives but an incomplete and uncertain protection. The indemnity allowances afforded may meet the doctor's charge or may fall far short of it. Further the subscriber can never know, until he arranges for service and learns the doctor's charge, how much protection he has. The indemnity arrangement may at times operate to increase the charge to the patient; the doctor knowing that the patient has insurance may charge more than he otherwise would, over and above the indemnity allowance.

Under the service basis physicians are paid what are decided between the plan and the profession to be fair fees. There is a definite control of doctors' charges. Under the indemnity basis there is no such control and the subscriber-patient is left open to what may be exorbitant charges -- charges such as (to quote some examples recently cited by a physician) "\$90 to cystoscopy and pyelography; \$175 for an appendectomy on a shop girl; \$300 on the line for cystoscopic investigation of dysuria; \$500 for a transurethral resection on a man whose income was a little over \$500 in his old age."^{3/}

The remarks of Mr. George F. Addes, Secretary-Treasurer of the United Automobile Workers (UAW-CIO), in testifying on the Wagner-Murray-Dingell Bill, are to the point here:

"The hospital service plan has been the more successful of the two Blue Cross plans. (In Michigan the medical plan calls itself a Blue Cross plan.) This success was due to the fact that in most cases total hospital costs have been paid by the Service and only in a limited number of cases has the worker been required to pay an additional amount...

.....The Michigan Medical Service has proved completely inadequate to provide for the medical needs of our members. While we have supported the plan because we have felt it is the best available plan, it has demonstrated to us that voluntary plans are definitely not the answer to the health needs of the American people. The plan has a number of fundamental weaknesses:

.....

(2) It provides only limited protection even for the restricted surgical services. The plan pays the doctor on the basis of an established fee schedule. If the subscriber's own doctor is not a participating member of the plan, he is not bound to accept the fee schedule of the Michigan Medical Service and he may charge any fee which he feels is reasonable and apply the amount received from the Service on his bill.

Where the subscriber's doctor does participate in the plan, he may nevertheless charge the subscriber more than the schedule rate if the income of the subscriber and his family is more than \$2500 per year.

^{3/} Cited by Dr. James C. McCann, President of Massachusetts Medical Service, in an address to the House of Delegates of the California Medical Association, California Medicine, July 1946, p. 12.

This income limitation provision has completely destroyed the original objective of the plan. For the past four years most of our members have averaged more than \$2500 income per year. They have discovered that in a very large proportion of the cases they are billed over and above the amount which the doctor receives from the Michigan Medical Service. So the worker finds that his premium has only partly paid for the limited surgical service which the plan provides.

As an illustration of this development, in 1941 the average cost to a Detroit worker for an appendectomy was \$75.00. The Michigan Medical Service provided a \$75.00 fee which usually took care of the doctor's entire bill. By 1946 the average cost to the Detroit worker for an appendectomy had risen to \$150.00. The worker today finds that after paying his premium to the Michigan Medical Service he still has a \$75.00 bill to pay the doctor.

(3) No real effort has been made to safeguard the interest of the subscriber so far as it concerns the amount of the fee charged by the doctor. The plan is controlled by the doctors and I suppose it is only natural that there has been little inclination on their part to remedy the complaints of subscribers. . . . ^{4/}

Mr. Addes's figures may be open to question, but there is no doubt that he expresses the feelings of the union members that they would prefer a plan wherein they had a certain and definite protection.

In some ways the indemnity basis is quite satisfactory for the physician. It subjects him to no restraints, leaves him free to charge what he wishes or what the traffic will bear; it provides the least deviation from past usages. However, the indemnity arrangement is unfairly advantageous to the doctor, and by so much is unfair to the patient. For the physician it is a sort of "eat your cake and have it too" arrangement. It puts a floor under his charges but imposes no ceiling. It protects the physician's income rather than the patient's pocketbook.

The service basis has advantages for physicians which compensate for its restraints upon their freedom in the matter of charges. In a sense the profession exists to serve the public and what is good for the public, in the long run, ought also be good for the profession. Prepayment facilitates the collection of charges, cuts down collection losses, enables physicians to secure fair fees from some patients from whom they would, in the absence of prepayment, obtain little or nothing. If prepayment works best and is most attractive to the public on a service basis then, assuming that the profession is equitably remunerated, it should be to the advantage of the profession to have it on this basis.

Another consideration is of importance. An indemnity arrangement is really one between the insuring agency and the insured; the physician is not fundamentally involved in it and therefore really deserves no place in its control. A service plan does involve the physician. By accepting the obligations which go with it, the profession earns the right to share in its control.

SOME OBSERVATIONS ON INDEMNITY PLANS

Indemnity plans are easy to establish. They can be established without any cooperation or action whatever on the part of the organized profession or individual physicians.

^{4/} Hearings before the Committee on Education and Labor, U. S. Senate, 79th Congress, Second Session, on S. 1606, Part 4, p. 2020.

That prepayment on this basis is readily salable to the public, at least until something superior is available, is shown by commercial insurance -- surgical expense insurance having been sold to over 9,000,000 people -- and by the record of some of the non-profit indemnity plans. Thus the Delaware plan has sold its medical indemnity contract to 36 percent of the population of the State, and leads all other plans in percent of population of the area enrolled.

The value of these plans to their subscribers depends primarily upon the degree of protection afforded, i.e., on the extent to which the indemnity allowances meet physicians' charges in full. As indicated previously the Delaware plan on the average is meeting 74 percent of physicians' charges and the Buffalo and New Hampshire plans, according to data of a year or so ago, were meeting 76 and 84 percent of total physicians' charges respectively. Another plan was meeting about 65 percent of charges. From these figures one may judge that some of these plans are probably giving about the same results as some of the service-indemnity plans, i. e., they are in effect providing service benefits to most subscribers of low income.^{5/}

Some of the indemnity plans operate on the basis of understandings with the organized profession of the area which tend to protect their low income subscribers against the possibility of extra charges by physicians. For example, in Delaware the State medical society has approved the indemnity schedule as representing fair fees for patients of moderate income. Thus though there is no formal restraint on physicians charging extra to low income patients there may be a certain moral restraint. In Ohio, the State society is encouraging physicians to accept the indemnity allowances of Ohio Medical Indemnity as full payment in the case of low income subscribers. There are one or two other indemnity plans where the same situation exists.

There is some evidence that indemnity plans, providing the allowances approximate the average level of fees in the area, have a certain tendency to "set" physicians' charges. The executive directors of some of the indemnity plans and insurance company officials having to do with medical expense insurance report such a tendency. These individuals would, of course, like to believe that such a tendency exists and to some extent the wish may be father to the thought.

Any such tendency, if it exists, only comes into play, of course, when a particular plan (or insurance company) has enrolled an appreciable proportion of the population of the area. The reasoning is that both doctors and subscribers have the indemnity allowances in mind and that the schedule tends to become a benchmark for both. Subscribers, it is said, tend to ask their physician if he will perform the operation for the allowed amount and to show some partiality for physicians who will give their services without an extra charge. Some physicians find it competitively worthwhile to let it be known that they will accept the plan's allowances "clear across the board" and will make no extra charge to any subscriber. The influence of an indemnity schedule upon physicians' charges is stronger in rural areas and small towns, where charges tend to be uniform, than in large cities where there is much greater diversity in charges.^{6/} The writer has talked with physicians in a rural

^{5/} The New Hampshire plan comes nearer to covering physicians' charges in full than the New Jersey plan (80 percent in Nov.-Dec. 1945), but this does not indicate that an indemnity plan in New Jersey would give higher coverage or that a service-indemnity plan in New Hampshire might not give still better coverage than the indemnity plan.

^{6/} Or, at any rate, an indemnity plan will tend to give better coverage of physicians' charges in a rural area where fees are uniform, than in an urban area.

state who were reluctant to participate in the indemnity plan of that state because they were certain it would "fix" their charges.

Whatever the natural effect of an indemnity plan upon doctors' charges may be, such a plan could do much to protect subscribers from extra charges by (a) publicizing its fee schedule, (b) urging subscribers to ask the physician ahead of time what his charge is going to be, and (c) publishing the names of those physicians who agree to accept the plan's allowances as full payment. However, such a program is unlikely in a plan controlled by the medical profession.

The big disadvantage of indemnity plans is that they do not give definite or complete protection. No matter what the average relationship of the plan's allowances to physicians' charges may be, instances do occur under these plans where subscribers of low income are charged fees double or even triple the allowances of the plan.

This defect can only be cured by the plan going on to a service basis. The average degree of coverage of physicians' charges can be increased by raising the plan's scheduled allowances. But to some physicians such an increase would only be an invitation to raise their own charges still higher. If full protection is to be given there must be agreement on the part of physicians to accept certain amounts as full payment for their services.

It is of significance that the executive directors and some of the physician board members of some of the more successful indemnity plans are thinking and hoping that in time their plans can be placed upon a service basis -- either for all subscribers or for all except those of quite high income. Other factors suggest that the indemnity basis may be an unstable one. The appetite for prepayment grows by what it feeds upon: the more the subscribing public becomes familiar with these plans the more it is likely to demand complete protection. If these plans grow and enroll a large proportion of the population of the area, sooner or later the question would come up, why not increase the allowances and have physicians accept them as full payment. Again, if and when a plan achieves a large coverage of the population of its area its schedule of indemnity allowances is bound to be a prime factor in the medical economics of the area. The profession would certainly wish to have a voice in the determination of this schedule as "fair". But if the allowances do represent "fair" charges either for all subscribers or for those under certain income levels then the question arises as to why physicians should be permitted to charge extra.

SOME OBSERVATIONS RELATIVE TO SERVICE PLANS

Plans operating on a service basis are more difficult to establish than indemnity plans. Service plans require the cooperation of the profession. If the profession will not give this cooperation then only indemnity plans can be established. Thus far only in a few States or areas has the profession been willing to cooperate in a plan providing service benefits to all subscribers irrespective of income.

A service plan cuts across the previously existing usages and customs of the profession. A full service plan, of course, does away with the sliding scale of charges -- the adjusting of charges to the patient's means.

PROBLEMS OF FAIR REMUNERATION UNDER A SERVICE PLAN

A service plan cannot work unless it provides fair remuneration to all physicians. Any scheme of fair remuneration must take quality of service in-

to account; it must permit the more experienced and qualified physicians to earn the higher incomes to which they are entitled. A fee schedule which is uniform for all physicians assumes that the services of all physicians are of equal value. The only way in which the more qualified physician can earn a higher income is by performing those services which give a higher return per unit of time required, or by performing a larger volume of service.

The prevailing differences in charges as between specialists and general practitioners in certain fields, e. g., obstetrics, suggest that a service plan, if it is to gain the participation of all or virtually all physicians, may find it necessary in certain fields to pay higher fees to qualified specialists than to non-specialists. The practices under a few existing plans tend to confirm this. Thus Massachusetts Medical Service provides that a subscriber (under the income limits for service benefits) is only entitled to service benefits for obstetrical care if she is delivered by a general practitioner; qualified obstetricians may levy a specified extra charge. Thus, this plan in effect provides for differential remuneration of specialists and general practitioners in this field. The King County (Seattle) plan has experimented with payment of extra fees to internists. The New York City service-indemnity plan under its experimental comprehensive contracts pays higher fees to qualified specialists, for services within the field of their speciality, than to general practitioners, this differential applying to virtually all of the specialties other than surgery.^{7/}

Just how far it might be necessary to go in providing differential remuneration to qualified specialists and to non-specialists is not clear. This for example might not be necessary in certain fields, possibly surgery. It is possible that here, because a large proportion of the work is performed by specialists, the prevailing fees tend to be what specialists ordinarily charge.

To be successful service plans must enable the exceptionally skilled or talented physician to earn the higher remuneration to which he is entitled. The payment of higher fees to qualified specialists (for services in the field of their speciality) will aid in this direction. It is also necessary that the fee schedule of the plan should provide adequate remuneration for the more difficult and complex procedures in relation to the fees paid for the less difficult or complex procedures. Some of the present plans fail to do this.

For example, there is in the mind of surgeons a relative value between a simple appendectomy and a complicated procedure such as a lung resection. Many of the present plans have a top fee of \$150 for any procedure. Many also pay \$75 for an appendectomy. If the fee for an appendectomy is fair, the fees paid for the more complicated surgical procedures are (by relation) unfairly low. The fees for these complicated procedures -- which are relatively infrequent in incidence -- will need to be increased if the plan is to provide fair remuneration to the exceptionally talented physicians who tend to perform most of these procedures.

NON-PARTICIPATING PHYSICIANS

It is doubtful if any service plan will work 100 percent upon a service basis. It is likely that there will always be some physicians, who may or

^{7/} Under the EMIC program in certain States qualified specialists in obstetrics are paid higher fees for maternity care than are non-specialists.

may not be of outstanding competence, who because of their reputation can charge (and collect) fees that are higher than those which a service plan would pay. These physicians will not find it worthwhile to participate and the only way in which a service plan can offer the services of these men to its subscribers would be through the provision of dollar allowances, equal to or somewhat less than the fees payable to participating physicians. Under a service plan, participating and non-participating physicians will be in competition, and subscribers will, other things being equal, prefer to receive service from participating physicians. In the long run, if a plan publicizes its list of participating physicians, and if it makes non-participating physicians collect their own fees (by paying the dollar allowance to the subscriber and not to the physician) the number of physicians who can afford not to participate will be small.

SOME DIFFICULTIES OF SERVICE PLANS

There are difficulties, other than those already mentioned, which confront service plans. One difficulty is the intense individualism of the profession. The individual physician feels that it is his prerogative to set his own fees and dislikes having any group even his own profession, "fix his fees." There is also the difficulty of securing agreement on a particular fee schedule. Some plans serve rural and urban areas. A fee schedule appropriate for the one may be a little low for the other. Each specialty group has its own ideas as to the value of its services, this value frequently being higher than that which other specialty groups believe warranted. The difficulty of reaching agreement on a fee schedule is obviously much greater under a service than under an indemnity plan, because under the former the plan's fee is all the doctor gets.

Another obstacle is the large number of individuals whose cooperation must be won. A hospital plan has to secure agreement only from a limited number of hospitals -- say 20 to 50. But a medical plan has to win the participation of hundreds or thousands of physicians.

The war years have been difficult ones for the establishment of service plans. The shortage of physicians and the high incomes of the public resulted in a "sellers" market. Physicians were able to demand and collect good fees. Because physicians had more patients than they could handle there was little incentive for them to enter a service plan with the idea that such a plan might increase the number of paying patients. As the medical situation reverts to normal more physicians will be willing to accept the obligations that go with a service plan in order to reap the benefits.

But the big difficulty in the way of the adoption or successful operation of service plans has been securing the necessary support and cooperation of the profession. Physicians have not had an adequate understanding of the potential benefits of prepayment to themselves and to the public. They have felt that a service plan was wrong in principle or have been fearful that it might diminish their incomes.

In brief, there are substantial practical difficulties in the way of establishment of service plans. If and when the medical profession believes wholeheartedly that prepayment will be advantageous to the public and itself, these difficulties can be overcome. Medical prepayment on a service basis is more than a fiscal undertaking. It is an arrangement under which the combined funds of a group of people are used for the provision of medical service to this group. It involves new habits, new ways of cooperation on the part of

both the public and the profession. Education of both groups is essential. A plan cannot succeed until both groups are ready to make the effort to make it work.

SOME OBSERVATIONS RELATIVE TO SERVICE-INDEMNITY PLANS

At present the bulk of the subscribers to medical plans are in the service-indemnity plans. If numbers are an indication these plans constitute the more successful type of plan at the moment. The advantage of these plans over the indemnity plans is that they guarantee service benefits to a portion of the subscribers. How much an advantage this is depends upon the proportion of subscribers entitled to service benefits, the proportion of the physicians of the area who are participating and the extent to which subscribers entitled to service benefits actually receive them.

Under a few of the plans with relatively high income limits for service benefits, a large proportion of the subscribers or potential subscribers will be entitled to service benefits. Under the plans with low income limits, say, \$2500 for a family, only a small portion of the subscribers will be so entitled. When the Michigan plan was first organized it was estimated that 80 percent of the subscribers would be entitled to service benefits. At present income limits probably not more than 10 or 20 percent of the subscribers come under the plan's income limits for service benefits.

The same shift has taken place with the other plans. Only one plan, Massachusetts, has raised its original ceiling for service benefits. As a result of the increase in income levels all of these plans are on more of an indemnity basis than when they were first started. Indeed the description of certain of these plans as "service" plans is misleading. The "service" element has become so diluted that the plans are really indemnity plans.

Against the advantage, greater or less, which accrues to these plans by virtue of the provision of service benefits to some subscribers, are certain disadvantages.

1. Insofar as the plans are on an indemnity basis they are a particularly bad type of indemnity plan in that generally the subscriber's contract does not contain a schedule of indemnity allowances, and hence the subscriber does not know just what he is entitled to by way of credits against the doctor's charge.

There is a certain praiseworthy frankness about a straight indemnity plan. The subscriber knows that he is entitled simply to certain dollar allowances. The subscriber knows what these are and he can make his bargain with the doctor accordingly. He is, so to speak, put on guard. The service-indemnity plans, on the other hand, which do not contain any schedule of indemnity allowances in the contract, give the subscriber a false security. The whole form of the contract, the talk about the plan being a "service" plan, leads him to expect that he will not be subject to an extra charge. These contracts give the impression of promising more than they actually deliver.

From this point of view those service-indemnity plans, which put a schedule of indemnity allowances in the contract together with a statement that participating physicians have agreed to accept these amounts as full payment for those under certain income limits, are on a better basis.

2. Any differentiation between those entitled or not entitled to service benefits on the basis of certain income limits is bound to be unfair and

arbitrary in certain cases. Thus under some plans a man and wife with an income of \$2400 would be entitled to service benefits, but a man and wife with three children and an income of \$2600 would not be so entitled.

3. It is difficult for the plans to guard against additional charges to patients entitled to service-benefits. It is not practical for the plan to secure and maintain any record of the subscriber's current income. Any information as to income, which the plan may request of the subscriber at the time of joining, soon becomes out-of-date. Hence, it is really up to the physician and the patient to enforce the service provision. To avoid the possibility of an extra charge the physician must ask the patient what his income is. Many physicians dislike to do this and some patients would resent it. However, if the physician does not inquire what the subscriber's income is and if the subscriber does not volunteer this information to the physician, an extra charge may readily occur.^{8/}

4. In some respects a service-indemnity plan is more difficult to present successfully to the public than either a straight indemnity or a straight service plan would be. People dislike discriminations based on income. The idea that some subscribers are entitled to one type of benefit whereas others are entitled to another type may alienate some potential subscribers. Salesmen of the Michigan plan frequently present this plan to potential subscriber groups as a straight indemnity plan. In many groups so few persons would be entitled to service benefits that it is felt wiser to delete all mention of the "service" feature.

5. Under some of the service-indemnity plans there is serious complaint from subscribers, just over the income limits for service benefits, of extra charges by physicians. This last point and some of the others are well illustrated by the following remarks of Dr. Atha Thomas, the president of Colorado Medical Service. He was speaking to members of the Denver Medical Society.

"....I wish to bring to your attention a major problem that is of vital concern to the Plan and to you. The growth of Colorado Medical Service during the past four years has been very gratifying....

"On the other hand, cancellations at the request of subscribers in the past year number 17,000. This is a disturbing figure as it represents a larger percentage of cancellations than in the past. It is particularly disturbing in that many of these subscribers have cancelled their Colorado Medical Service but not their Blue Cross contracts.

"We have discussed with you on numerous occasions the problem of the participating physicians; committees have been appointed by the specialty groups to make adjustments in the fee schedules, and we have otherwise made requested changes which are of benefit to the doctors. Rarely, however, have we discussed with you the Plan from the standpoint of benefits to the subscriber. I am bringing this problem to you because the time is fast approaching - if not already here - when we must answer to the subscriber as to whether or not he actually benefits by being a member of the Colorado Medical Service. Illustrative of this problem, let me quote from a letter recently received from the

^{8/} The Virginia plan (and possibly some others) uses the following device. Physicians are required to send their total bill to the plan, no bill being sent directly to the patient. The plan notes on a copy of this bill the amount of its payment to the physician and sends this to the patient with a slip enclosed to the effect that no extra charge needs to be paid if the subscriber's income is below the specified levels.

head of a concern whose employees make up one of our large subscriber groups, and who, incidentally, is an enthusiastic supporter of the Plan:

"I wish to call to your attention a matter of some concern to me. It may be that I just happened to be in the way recently to receive what seems to me an increasing number of reports of unhappiness by Medical Service policyholders over alleged overcharges for services by participating physicians. A number of these instances have been mentioned by our employees which reminds me that perhaps we should do something to educate policyholders at least among the folks at our company, on the important question of 'How to Buy an Operation.' Perhaps some of the comment has been created by the recent poll of our employees to adopt the Comprehensive Blue Cross Plan. At that time a number of remarks were made. A typical one was 'Blue Cross service is all right, but if they were to raise the Surgical Plan even a dime, it would only give me an excuse to drop my surgical insurance...'"

"Recently committees from the Denver Police and Fire Department called the Office of Colorado Medical Service to discuss this same problem. They complained about the excessive surgical fees charged beyond the amount paid by Colorado Medical Service. The only statement that we could make in reply to this complaint was that any employee having surgery performed could expect to be charged an additional amount by his doctor if his income is over the specified limit, which, in the Police Department at present, is the case with the majority of their employees. Following this incident, there was a large cancellation of Surgical Plan subscribers from the Police Department, and we are further advised that we may expect similar action from the Fire Department.

"The Bureau of Reclamation, the largest group enrolled under the Surgical Plan, has also informed us through their group leaders that the plan is not favored because in their opinion it gives financial protection to the doctor but not to the patient. They have arrived at this conclusion through their own experience. They charge discrimination against the subscribers in the efforts of the Colorado Medical Service to protect the doctor financially.

"Because of the fact that the additional charges made by many doctors are considered by both the patient and his employer as exorbitant, some employers have insisted that the employee consult them before he resorts to surgical treatment in order that they may advise the employee as to what doctors are making these so-called exorbitant fees. This in our opinion is effecting a black list of physicians and is a very undesirable practice; yet it is justified in the opinion of the employer. The rumblings of these charges are to be heard in any group of Colorado Medical Service subscribers, and they are getting louder every day. Cancellations of Surgical Plan contracts are getting heavier because of these complaints.

"This plan is sold to subscribers as the doctors' own plan, initiated and sponsored by organized medicine, and for that reason is presented as superior to any commercial indemnity insurance and we know that it is superior. It is a service plan through which we promise persons in low income brackets that their surgery is to be paid in full. Because of post-war inflation this same group of people which constitute the greater proportion of our subscribers have had salary increases. These increases have not really taken them out of the low income group, but merely put them over the income limits of Colorado Medical Service. These brackets were made in 1939 when it was estimated that 75 percent of the employed people would be under this limit. A large percentage of our present subscribers enrolled in the plan when their wages were in this income limit, and even though their wages have been raised, they are actually poorer now than they were then, because of the tremendous increase in the cost of

living. Imagine then how they feel after an operation, to learn that they are expected to pay considerably more than the prescribed fee paid by Colorado Medical Service! As a result, it is difficult to convince them that they have benefited in any way by belonging to the Colorado Medical Service. We are not asking for any action or decision on this problem by the Society at this time, but we do wish to call it to your attention, because we feel dire consequences will result unless more consideration is given these subscribers by participating physicians."^{9/}

It is the writer's belief that the problem here stressed, that of complaint against extra charges from subscribers with incomes just over the income limits for service benefits, confronts other service-indemnity plans. This is certainly true of the Michigan plan. The very nature of the service-indemnity plan breeds these complaints. In the press of mass selling, many subscribers above the income limits for service benefits are apt to receive the notion that they are entitled to service benefits. The fact that some subscribers are entitled to service-benefits makes others, little better off economically, desire the same benefits. The very nature of the contract, the stress upon "service", the fact that there is no indemnity schedule in the contract, gives people the idea that they are entitled to service as needed and makes them dissatisfied when they are charged extra.^{10/}

There are three ways by which service-indemnity plans can meet the situation outlined. One is to shift to a straight indemnity basis, a move which is hardly likely to impress the public as being in its interest. The second is to raise the income limits for service benefits. This latter step will alleviate the problem somewhat, but will project the issues and the complaint to a new, higher-income, group of subscribers. It would seem that the only final solution would lie in putting the plan on a full service basis, i. e., service benefits for all regardless of income.

It is evident from all this that the service-indemnity basis, as a sort of half way house between indemnity and service, has serious defects. By calling attention to these defects the writer does not mean to imply that these plans are not more valuable to their subscribers than straight indemnity plans would be.^{11/} By and large they probably are more valuable. But they are, it seems to the writer, an unstable arrangement; their operation generates forces which are likely, sooner or later, to result in their being placed upon a full service basis.

SERVICE BENEFITS FOR ALL SUBSCRIBERS

In the long run if medical plans are to meet the needs of the public it would seem that they would have to be placed on a full service basis.

^{9/} Editorial, Rocky Mountain Medical Journal, January, 1947. Quoted in Public Health Economics, (School of Public Health, University of Michigan) March 1947, pp. 186-188.

^{10/} It is of interest that the straight indemnity plans do not report any widespread complaint from physicians. These plans make it quite clear what the subscriber is entitled to. They do not promise more than they deliver.

^{11/} The value of service-indemnity plans to their subscribers cannot be determined without data showing the proportion of cases in which subscribers receive service benefits, and as regards cases in which there is an extra charge, the extent to which plan payments meet total charges. Apparently there is not a single one of the service-indemnity plans which is now compiling such data.

The indemnity plans need the same type of data for any evaluation of their usefulness. Only one of these plans is routinely compiling this information.

Such a step would make the plans far more attractive to the public. It would enormously simplify promotion and sales effort. Also in the long run the plans will be more likely to succeed from the standpoint of the interest and backing of the profession if the prepayment effort is an all out one.

The extension of service benefits to all income groups would require the provision of fair and adequate remuneration to the profession and the ability of the plan to enroll a cross-section of the population. If a certain level of fees (as indicated by a fee of, say, \$75 for a simple appendectomy) gives fair remuneration to the profession under a plan with an income ceiling for service benefits such that, say, half of the population is entitled to service benefits, then a certain higher level of fees (as might be indicated by a fee of \$85 or \$90 for a simple appendectomy) would provide fair remuneration if all income groups were entitled to service benefits. This matter would be affected by current practices with regard to payment for care of the indigent. If physicians in an area are expected to provide care for the indigent without remuneration then the level of fees under a plan providing service benefits to all income groups would have to be higher than under a situation in which physicians were fairly and adequately paid for their services to the indigent.

The plan must also be able to enroll a fair cross-section of the population and convince the medical profession of its ability to do this. If fees are set at a level which would give the profession a fair income if a cross-section of the population joined, but actually enrollment was mainly among high income groups, the profession would tend to lose income. The profession would be accepting lower fees than it now secures from the higher income group, without the compensation of receiving higher fees than it now receives from the lower income group.

Some idea of what would be involved in placing some of the present indemnity and service-indemnity plans upon a full service basis can be gained by considering the present experience of these plans. The Delaware plan is now meeting about 74 percent of the aggregate charges to subscribers. To meet the aggregate of doctors' charges in full it would be necessary to increase the fee schedule by about a third. The analogous figures for the Buffalo, New Jersey and New Hampshire plans are 32, 25 and 19 percent, respectively. Actually, since physicians do not collect their full charges by a considerable margin, no such increases would be required in order to give the profession as a whole the same average income per patient as it is now receiving. Further it must also be taken into consideration that the operation of a prepayment plan enables physicians to secure a fair fee from many subscriber-patients from whom they would otherwise obtain little or nothing. The decision as to what increase, if any, would be necessary needs to be made in the light of what fee schedule would be necessary to provide adequate remuneration to the profession as a whole. In some cases the present plans could probably be placed upon a full service basis without any increase in the fee schedule; in other cases some increase, but less than that required to meet present average charges in full, would be required.

CONCLUSIONS

1. Hospital and medical plans should provide their benefits in the form of service rather than in the form of indemnity allowances. Only on a service basis can the plans adequately meet the needs of the public.

2. Prepayment on a service basis requires fair and adequate remuneration of hospitals and physicians. It requires the full cooperation of both and their desire to make prepayment work.

3. The provision of fair compensation to physicians probably requires differential remuneration of qualified specialists (for services within the field of their specialty) and non-specialists. It requires also that the more difficult procedures shall be adequately compensated relative to the less difficult ones.

4. Indemnity and service-indemnity medical plans are unstable arrangements. Their operation generates forces which press towards placing the plans upon a full service basis. Both types of plans have defects which can only be eliminated by their transformation into full service plans.

CHAPTER 22

THE COORDINATION OF MEDICAL AND HOSPITAL PLANS*

One of the most important problems facing medical and hospital plans is that of their proper coordination with each other. On this point there are offered the following observations:

There are four types of relationships to be found between the medical and hospital plans:

1. *No Coordination: The plans are separate and distinct and there is no coordination of their activities.*

This relationship or lack of relationship exists in Washington, Oregon, Northern California and Pennsylvania.

2. *Partial Administrative Coordination: The two plans are separate corporations, with separate boards and separate executive directors but to some extent they have a combined administrative staff.*

This relationship exists between 9 medical plans and 14 hospital plans. In most cases the medical plan performs certain functions for itself, namely approval of claims, payment of physicians and maintenance of relationships with the profession. Generally enrollment, billing and the keeping of records to determine subscriber eligibility is performed for the medical plan by the hospital plan, the medical plan paying the hospital plan a certain percentage of its income for these services.

This relationship exists in several instances where the Blue Cross and medical plans do not serve the same area, where, for example, there is a State-wide medical plan and two or more local hospital plans.

3. *Complete Administrative Unification: The two plans are separate corporations each with their own board, but they have a single executive director and administrative staff.*

This is the most common relationship at present. A single administrative staff under a single head administers both plans. The general contractual relationship is that in which the hospital plan agrees to administer the medical plan and the latter has no employees of its own. The two plans are separate only in their finances and policy making bodies. Administrative expenses are shared between the two plans, usually on the basis of relative gross incomes.

4. *Complete Integration: One corporation offers both hospital and medical service.*

There are nine such plans.^{1/} The plan keeps track of income from and cost of benefits for the hospital and medical contracts respectively, and makes each contract pay its own way. No attempt is made to break down administrative costs for the two contracts. In some of these plans the hospital contracts are underwritten by the hospitals and in two the medical contracts are underwritten by the participating physicians. But whatever may be the bookkeeping arrangements, all the assets of the corporation are available to back up both contracts.

*Much of the material in this chapter appeared in an article by the writer and Henry F. Vaughan, Jr., in the Journal of the American Medical Association, May 5th, 1945, p. 22.

^{1/} Also the medical plans in Washington and Oregon, and California Physicians' Service in the northern part of its territory, are of this type in that a single organization offers both services.

The common goal of both the hospital and medical plans should be to give protection against the costs of illness to as many people as possible. Which of the four possible relationships will facilitate the achievement of this goal most quickly and effectively?

COMPARISON OF THE FOUR RELATIONSHIPS

1. NO COORDINATION

This relationship is thoroughly undesirable. In the first place it is wasteful and uneconomical. Each plan does its own selling, billing and subscriber record-keeping when one organization could perform these functions for both plans at much less cost. It prevents the medical plan from utilizing the facilities, and from building on the already developed enrollment, of the hospital plan (or vice versa).

In the second place it leads to competition and conflict. Because employers are reluctant to make two payroll deductions to separate organizations, the medical plan is forced in self defense to develop its own hospitalization coverage (as in Northern California) and the hospital plan to develop its own medical coverage (as in Oregon). Hence the situation develops into two plans, one sponsored by the medical profession and the other by the hospitals, competing with each other. Competition is a good American institution in its place. However, these plans are or should be non-profit community services. They gain prestige and public support, in part, because of sponsorship by the medical profession and the hospitals. When the plans compete with each other that prestige and public support is dissipated. Nothing could be more detrimental to the growth of voluntary plans than the present situation on the West Coast. The potential market for prepayment is enormous but little headway can be made until the medical and hospital plans get together.

2. PARTIAL ADMINISTRATIVE COORDINATION

This is an advance over "no coordination" because it at least brings the two plans together and avoids competition and strife. A disadvantage may be that the cord binding the two plans is tenuous and may break down leading back to complete separation of the plans.

When two plans cooperate, certain activities must be performed jointly or by one plan for the other. Enrollment, collection of subscription charges, maintenance of records showing subscriber eligibility for care, publicity and public relations are of this character. There must be joint use of certain office facilities. Furthermore there must be coordination of the two plans with respect to major policies. In order not to confuse the public and impede acceptance of the two plans, enrollment regulations must be similar, the provisions as to types of cases covered, or not covered, waiting periods, etc., must be alike. Any change in the rates or benefits of the one which renders it more or less attractive will affect the sales of the other which is coupled with it.

A difficulty with "partial administrative coordination" is that, in effect, it sets up two masters in the same household. The director of the medical plan may have his ideas as to how enrollment should be conducted and on the choice of the man or men to do it. The two directors may have conflicting ideas on the best methods of keeping subscriber records, on publicity and public relations. Each director, in time, will tend to have his own ideas as

to how the other plan should be run. If either plan is forced to raise rates or to cut benefits in order to make ends meet, this will slow down sales of the other, and the director of the other plan will have his own ideas on how the situation could have been avoided or should be handled. In short, the two plans are really joint undertakings. The public which pays its dues to one organization thinks of them as one and cannot be persuaded differently. The success of the one affects the success of the other.^{2/} Yet there are two administrators, and this always makes for trouble.

There are also questions of prestige. If the hospital plan is well developed by the time the medical plan is offered, the two plans together will be sold as Blue Cross, and the medical plan and its director will not like this.^{3/} If the Blue Cross plan does the selling for the medical plan, it is the Blue Cross representative who meets potential subscribers. His main loyalty is to that organization. This is not only true of the field men but of all Blue Cross employees who give some of their time to the medical plan. The hospital plan may be pushed; the medical plan considered an extra. The Blue Cross director has to sell a service concerning which he has no say.

The director of the medical plan meets with the Board of Directors of the medical plan, and the director of the hospital plan meets with his Board. Neither Board has first hand knowledge of the problems of the other plan with which they are coupled. Conflicts between the two Boards on joint matters may not be easily resolved. Further, if friction between the two directors reaches the point where neither will give way to the other, then each Board will tend to back up its own director.

3. COMPLETE ADMINISTRATIVE UNIFICATION

This is a workable arrangement and it is functioning quite satisfactorily in the case of the paired hospital and medical plans which are on this basis. Administratively there is a single organization with a single head. The arrangement permits the hospitals to sponsor and back the hospital plan and the medical profession to sponsor and back the medical plan.

The drawbacks of this arrangement are that it is not the most convenient method of securing coordination between the Boards of the two plans, and that the executive director is in a sense serving two masters.

The executive director of the New Hampshire-Vermont hospital and medical plans in his 1946 annual report to both plans writes as follows:

"The combined operation of the two services, Hospitalization and Physician, is so involved that it becomes more and more difficult to sort out the affairs of each for a separate report. With the permission of the President of each corporation we are issuing a joint report this year. Those who are interested in the affairs of either corporation are necessarily interested in the affairs of the other."

^{2/} This is well illustrated by what has been happening in Michigan. The Michigan hospital plan has been having administrative difficulties and trouble with its hospitals. Since Jan. 1, 1945 it has failed to grow, in fact has lost members. Michigan Medical Service grew but little during 1945 and in 1946 it too lost members.

^{3/} In Michigan the medical and hospital plan are both called Blue Cross plans, and both plans have adopted as their symbol a blue cross with an inner shield within which is a caduceus.

Where the two plans are operated together their affairs do indeed become so intertwined that it is difficult to say where one leaves off and the other begins. The success of the one is bound up with the success of the other. Should the hospital plan fail for some reason or other, the medical plan would be pulled down into the same wreckage, or vice versa. Inevitably the one plan would have to come to the rescue of the other. If it is found that a poor choice of executive director has been made and the plans are poorly administered and fail to grow, the boards of both plans would be equally concerned in the choice of a successor.

On many matters, as has been shown, there must be joint determination of policy between the two plans. What size groups should be enrolled? What percentage of participation within a group should be required? Should individuals be enrolled? On what basis? Should rural enrollment be undertaken? What types of publicity should be undertaken? Should higher rates be charged to individuals who drop out of groups? The one Board must agree to any change of rates or benefits desired by the other. On all these matters of joint policy or interest, the executive director must go back and forth between the two Boards. One Board decides on a certain matter. The other Board considers and suggests a different solution. The first Board must reconsider. It is a waste of time on the part of all concerned. Joint meetings of the two Boards and interlocking of some of the personnel will help to cut down this waste.

Another drawback of this arrangement is that the duality of the plans is confusing to the public and is a handicap to effective promotion and selling. Subscribers pay their money to a single organization and they tend to think of this organization as offering both hospitalization and medical service. The two different subscriber contracts and the different names and emblems of the two plans tend to confuse people. Obviously from a strictly promotional standpoint it would be far easier to gain public acceptance of one plan than of two plans with their separate names and emblems.^{4/}

Under "complete administrative unification", the executive director of the two plans is apt to feel that he is really the employee of one or the other. Under most existing plans with this arrangement the director draws all of his compensation from the hospital plan. Under a few he receives an extra \$1,000 or \$2,000 from the medical plan. This situation encourages the executive director to feel that his allegiance is wholly or mainly to the hospital plan, and, as under "partial administrative coordination", possibly to think of the medical plan as a side-line.

The medical profession may think that "complete administrative unification" is preferable to one Board for both plans, because under the former it can have full control of the medical plan. Actually this is illusory. Where so many matters are of concern to both plans, then in effect any decision of one Board must be approved by the other. The Board of one plan must assent to any major decision of the other plan Board. This means that one Board

^{4/} The awkwardness of the duality of the plans from a public relations standpoint is well illustrated by the letterheads of many of the allied plans. They have a single letterhead for both plans, e.g., "Massachusetts Hospital Service-Massachusetts Medical Service." The average person receiving a communication on such a letterhead is apt to wonder, with whom am I dealing, one organization or two?

shares control with the other. The separation of the two Boards simply makes it more difficult for joint decisions to be arrived at.

Under "complete administrative unification" the medical plan has a head but no body. An arrangement under which one plan entrusts its entire fortunes, all its administration, to another plan does not seem to be a sound one for the long pull. If one visualizes the arrangement as one in which the executive director and the staff serves the two plans equally, then it is a case of one person or one group serving two masters, which again does not seem to be a sound arrangement. The solution, when both groups are ready for it, is "complete integration" of the two plans.

One sees the difficulties of merely administrative unification in clearer perspective if one projects thought to the time when dentistry and nursing are offered on a prepayment basis. Will there be a dental Board and a nursing Board with the director of the hospital plan serving as executive for all? Obviously, merger is the answer.

4. COMPLETE INTEGRATION.

This seems the common sense arrangement when the two groups are ready for it. It is the one to which the plans probably will ultimately come. Under this arrangement the hospital plan, as such, ceases to exist; the medical plan, as such, ceases to exist. Instead there is a combined medical and hospital plan - a health service plan.

Under this arrangement there is one single corporation with one Board and one director. There is complete coordination of medical and hospital prepayment because they are unified. One single organization gives maximum economy, single authority, maximum public acceptance and equal responsibility on the part of the plan's employees to all services which they render. The director of this one health service plan would feel equal responsibility to both hospital and medical prepayment. Both the hospitals and the medical profession should be equally represented on the Board of Directors, which should have heavy representation from the public. It goes without saying that the name of the organization should reflect its makeup and purpose. It should not be _____ Hospital Service but _____ Health Service.

An important advantage of "integration" is that it facilitates solution of the vexing problems of the inclusion of radiology, pathology, and anesthesia services in hospital and medical plans. These services when performed by physicians are medical services yet the charges for them often or usually appear on the hospital bill and are therefore thought by the public to be hospital services. Physicians in these specialties quite properly desire that these services shall be included in the medical rather than in the hospital plan. Yet until the medical plan has as extensive a membership as the hospital plan, the inclusion of these services in the medical plan and their exclusion from the hospital plan has the disadvantage for the subscribing public that a lesser portion of the hospital bill is covered. Furthermore even if enrollment in both plans is coextensive, and the aforementioned services are offered under the medical plan, administratively it is simpler, where the charges for the mentioned services appear on the hospital bill, for the hospital plan to pay the full hospital bill and to debit the medical plan for its expenses on behalf of these services, rather than for one organization to pay part of the bill and the other organization pay the other part. All of these difficulties are avoided if Blue Cross and medical plans are transmuted into a joint hospital and medical plan - a health service plan - with a changed name and changed Board of Directors to give proportionate representation to both groups.

There are several difficulties in the way of ready acceptance of "complete integration". One difficulty is that in most places neither the medical profession nor the hospitals are ready for it. They are too afraid of each other to get at such close quarters. (In discussing this proposal one hears the doctors say they are against it because the hospitals would control, and the hospitals say they are against it because the doctors would control. Perhaps this arrangement is only feasible when the public becomes the arbiter between the two groups, i.e., when dominant control of hospital and medical plans shifts to the public.)

A second difficulty is that unification of the two types of plans will not be desirable if it results in a loss of interest in or support to hospital and medical prepayment on the part of hospitals and the medical profession. If it is purchased at this cost, then the price is too high. Until the medical profession, for example, is so convinced of the benefits of prepayment for the public and itself that it will give staunch support and cooperation to medical prepayment irrespective of whether the plan is its own plan or the community's, integration of hospital and medical plans may not be desirable. Further a wedding of hospital and medical plans is apt to be fruitful and lasting only if it is a joining of equals, i.e., until membership in the medical plan begins to approach membership in the allied hospital plan and until the medical plan has substantial reserves to contribute towards the joint reserve of a unified plan.^{5/}

A third difficulty is that the laws of a number of States say that medical and hospital prepayment must be provided by separate corporations. It would seem, however, that these laws could be changed. It would also be possible in some instances to have two corporations but have the same Board members on each.

A fourth difficulty to union of hospital and medical plans is that the hospital plans have their central organization which is affiliated with the American Hospital Association, and the medical plans have their central organization which is closely tied to the American Medical Association. Unification at the local level should be attended by unification at the national level. This problem merits separate discussion.

COORDINATION BETWEEN HOSPITAL AND MEDICAL PLANS AT THE NATIONAL LEVEL

It is obvious that close coordination of hospital and medical plans at the local level requires a similar coordination at the national level. For example:

1. Various interplan activities -- enrollment of national accounts, the problem of uniform enrollment regulations, consolidated billing, transfer of members between plans, public education activities, public relations -- are of equal interest to both hospital and medical plans. Only one central organization could function effectively in these fields.

2. The approval programs for hospital and medical plans obviously need to be coordinated, i.e., made into a single program. It would obviously be

^{5/} Most of the present combined hospital-medical plans are defective from this general standpoint and are not really successful. Thus the medical plans in Washington and Oregon which offer hospitalization do not have the cooperation and support of the hospitals, and most of the Blue Cross plans which expanded their contracts to include certain physicians' services have done so with the tolerance but not the active cooperation of the medical profession, and in one case with the active opposition of the organized profession. In other words, timing -- the stage of development of the plans and the stage of the thinking of hospital personnel and of the medical profession -- is of the essence.

very awkward, assuming that both the hospital and medical plan approval programs are to be meaningful, if a hospital plan were approved by the American Hospital Association, but the companion medical plan were disapproved by the American Medical Association.

3. It is a waste of time, effort and funds for the executive directors, leading board members and top staff personnel of hospital plans to attend two conferences a year of hospital plan personnel to discuss problems which are germane to both types of plans, and then for the same individuals to attend additional conferences devoted to problems of medical plans, which problems are again germane to the problems of hospital plans.^{6/}

These factors and many others which will readily come to mind dictate merger of the two central organizations of the hospital and medical plans. Obviously the resultant organization should draw representation from but should not be affiliated with either the American Hospital Association or the American Medical Association. Equally obvious it should have strong representation from the public.

CONCLUSIONS

Cooperation between medical and hospital plans at the local level is essential. This cooperation can be achieved under various arrangements, any one of which can function at least temporarily with success, depending upon the stage of thinking of those who do the cooperating. Complete unification of hospital and medical plans into Blue Cross health service plans seems to provide the final and best solution. It represents the end of the road. But less forthright arrangements may not be without their temporary value.

Cooperation between the two types of plans at the national level is no less essential. The present central organizations of the two types of plans should be merged into a single organization which has representation from but is not affiliated with either the American Hospital Association or the American Medical Association.

^{6/} Since this was written it has been announced that henceforth the two central organizations, i.e., the Blue Cross Commission and Associated Medical Care Plans, will hold their annual conferences jointly. It has also been announced that they will cooperate with respect to compilation of membership and utilization statistics.

CHAPTER 23

THE INCLUSION OF RADIOLOGY, PATHOLOGY, ANESTHESIOLOGY AND PHYSICAL THERAPY IN HOSPITAL AND MEDICAL PLANS.

In many localities there have been strong controversies in the past as to the offering of these services by hospital plans. The physicians practicing these specialties in hospitals have maintained that their services were medical services and should not be included in a hospital plan. Hospitals and hospital plans have often maintained that these services when provided in a hospital were hospital services and should be included in the plan. The extent to which one side or the other has had its way is roughly indicated by the fact that of the eighty odd hospital plans slightly more than half include x-ray service and about the same proportion pathology service.

An understanding of the situation requires knowledge of the arrangements under which these services are provided in hospitals.

The large amount of equipment required for the practice of radiology in a hospital makes it uneconomical for this service to be provided by a number of competing physicians. One physician or group of physicians must provide the service. Further this service is not so much one provided directly to the patient as it is rendered as an aid to other physicians in serving the patient. For these reasons hospitals have assumed certain responsibilities for the provision of these services within their walls.

In the vast majority of hospitals, the hospital owns the x-ray equipment, pays the salaries of the technicians and other employees of the x-ray department and provides the necessary supplies. The most common financial relationship between radiologists and hospitals is one where the radiologist receives a percentage of the gross or net income of the department. The next most common relationship is employment of the radiologist on a full or part time salary. About ten percent of the radiologists practicing in hospitals--these men often own the equipment -- pay the hospital a certain sum for the privilege of conducting the x-ray department; the radiologist assumes all expenses of the department and all fees belong to him.

The most common arrangement for the provision of pathology services is where the hospital owns the laboratory and its equipment, pays the salaries of all employees, and the pathologist is employed on a full or part time salary. The usual arrangements as regards physical therapy services are similar -- the physical therapist being employed on a full or part time basis or receiving a percentage of the income of the department. As regards anesthesia services, in many hospitals these are performed by nurse anesthetists employed by the hospital; in some hospitals this service is performed by physicians on a full or part time salaried basis, in other hospitals by physicians who have no financial relationship with the hospital though the latter may bill the patient on their behalf.

What is common to virtually all of these arrangements is that the hospital assumes a certain responsibility for the provision of the service, and that almost always the bill for these services is rendered as part of the

hospital bill. This last has led the public to think of these services as hospital services.

Hospital plans desired to cover these special services in their contracts. They did so because these services were generally considered by the hospitals and the public to be hospital services, because the public wanted as comprehensive a coverage of the hospital bill as possible and because exclusion of these services gave rise to misunderstanding and complaint on the part of subscribers. In many localities however some or all of these specialists strongly opposed the inclusion of their services under the hospital plan. The reasons for such opposition were as follows:

1. These physicians wanted it clearly understood that their services were medical services; they wanted the same prerogatives as other physicians; they felt that inclusion of these services under a hospital plan would injure their prestige with the rest of their profession and the general public.

2. So long as the general medical profession did not fully approve of or did not participate in medical prepayment, the physicians of these specialties did not want their own services included under a prepayment plan.

3. Many of these physicians were anxious to maintain or strengthen their economic and professional independence of hospitals; they wished to avoid becoming salaried employees of the hospital.

4. They believed that inclusion of their services under the hospital plan might result in loss of income, a belief strengthened by the fact that in some cases proposals for inclusion of their services were made without giving them adequate voice in the determination of the basis and amount of remuneration for their services. For example, where the plan paid all its hospitals a fixed amount per day, a particular hospital might receive on the average less than its regular billings. Where radiologists received a percentage of the income of the x-ray department, this might mean a loss to them. Oftentimes the arrangements which hospitals proposed to their radiologists for sharing this loss did not seem fair to the radiologists, or they were opposed to the whole idea because in negotiations between the plan and the hospitals they were not considered as principals.

Fortunately the controversy over inclusion of these special services appears to be in process of disappearance or settlement owing to the development of medical plans, or the broadening of hospital plans into health service plans. This development has tended to erase any differences as to principles; what remain are certain questions of a technical nature which can be easily resolved.

With the development of medical service plans the profession placed a stamp of approval on medical prepayment. The physicians in these specialties then were able to feel that they would no longer lose prestige if their services were offered under prepayment.

Where the hospital plan was broadened into a joint hospital-medical plan, then any controversy as to whether these special services should be offered lost all point. All that mattered then was that these services should be denominated as medical services and that the physicians providing them should be adequately remunerated.

Where separate medical plans were developed, the controversy lost most of its point. In the first place pressure from the hospital plans for coverage of these services was removed when it became possible to offer coverage of these services under a related medical plan. Secondly, hospitals began to give way on a point dear to the heart of these specialists. The hospitals

became willing to concede that these services when provided in hospitals were medical services. Once it was agreed that these services were medical services, then the question of whether they should be offered under a medical service plan, or under a hospital service plan which announced that its contract covered hospital services and "certain medical services," became more a matter of expediency than of principle. Assuming that appropriate bases and rates of remuneration for these special services would be established in either case, then so long as the hospital plan had more members than the medical plan, it was perhaps more advantageous to all concerned if these services were offered under the hospital plan, but it was not a matter of great moment.

The basis upon which this controversy has been settled or is in process of being settled is indicated by the following comment:

"Congratulations and thanks are due to the Hospital Association of New York State. Last fall the Association adopted a resolution to the effect that radiology and pathology would be dropped from Blue Cross benefits when medical service plans were prepared to furnish these medical services among its benefits on a fee basis.

"Last month the Association announced the following agreement with the Medical Society of the State of New York:

"(a) It is agreed that Pathology, Anesthesiology, Roentgenology and Physical Therapy are medical services and the practice of medicine.

"(b) That these specialties are so recognized.

"(c) That an equitable arrangement can be made between the individual hospitals and the doctors who practice these four specialties recognizing the above principle, whereby the hospital may bill for these services in the name of the person rendering the service. (This can be done by inserting the name on the regular hospital billhead, i. e.: Instead of X-ray, indicate "Professional Services of Dr. _____, Roentgenologist.")

"(d) Until such time as a Medical Service Plan is available, there is no objection to inclusion of these medical services in the hospital service plan contract as long as the principle of recognition and proper remuneration to these specialists is carried out." 1/

When hospital and medical plans are amalgamated into health service plans then this controversy will entirely disappear -- which is a reason in favor of such amalgamation.

1/ Monthly News Letter of the American College of Radiology. Quoted in California and Western Medicine, Vol. 63, No. 1 (July 1945) p. 31.

PART IV

CONCLUSIONS

CHAPTER 24

CONCLUSIONS

BENEFITS OF THE PLANS

The first conclusion of this survey is that hospital and medical plans are beneficial for the subscribers, the hospitals, the medical profession and the general public. The plans enable the subscribers to pay for hospital and medical care in a convenient manner. They give protection against the risk of heavy sickness costs. Having this protection, people obtain care who otherwise might go without, and they tend to obtain care more promptly. Some persons, who in the absence of advance provision would be forced to ask for charity care, are enabled to pay their own way.^{1/} Knowledge that all or the greater part of the costs of his illness will be taken care of aids recovery of the subscriber-patient. He feels free to stay in the hospital as long as may be necessary. The plans enable the subscribers to receive care in better hospital accommodations than they would otherwise be able to afford.

The plans are beneficial to hospitals and physicians. They facilitate the collection of charges. They enable hospitals and physicians to obtain fair remuneration from some subscriber-patients who without the plan would be able to pay little or nothing. They tend to increase and stabilize the incomes of hospitals and the profession. The operation of the plans results in an upgrading of the demand for hospital accommodations: less demand for ward care, more semi-private and private care. Prepayment facilitates care of the patient: physicians feel free to recommend services -- hospitalization, an elective operation, extensive x-ray and laboratory tests, which they might not feel free to recommend if they knew that the cost would be a burden to the patient. Also the insured, worry-free patient is a better patient and is apt to recover sooner than the one who is fretting about how the bills for his illness will be paid. The plans improve the relationships of patients on the one hand and physicians and hospitals on the other. They tend to remove the financial element from this relationship. The insured patient who has his bills paid in whole or in large part by the plans will be a more satisfied patient than the non-insured patient who has large bills to pay.

^{1/} It is the universal testimony of hospital administrators that the operation of the plans, and of commercial insurance also, reduces the volume of free care. Physicians, welfare department officials, executives of councils of social agencies, community chests, and similar organizations in a number of localities, also expressed the opinion that the plans have reduced substantially the volume of charity care. It has not been possible statistically to determine the extent of this reduction. Data from many communities in which the plans have achieved substantial enrollment show a decline in the proportion of free or ward days and an increase in semi-private and private days. Thus in Cleveland, the number of free days billed to the Welfare Federation declined from 204,517 days in 1936 to 78,135 days in the first 11 months of 1946. In the case of the Rochester General Hospital the days of ward care declined from 57,409 in 1935-6, when the Rochester plan started, to 24,081 days in 1945, and the days of semi-private and private care increased from 37,875 to 90,899. Figures of similar import could be quoted for many other communities where the plans have achieved wide coverage. However, to what extent these changes have been due to the operation of the plans (and of other types of hospital insurance) and to what extent to the improvement of economic conditions over the same period it is impossible to say.

The benefits of the plans to hospitals and physicians will depend in the last analysis upon the adequacy of remuneration. On occasion some plans have provided unfairly low remuneration to hospitals and physicians; on other occasions the latter have been paid too well. Differences of opinion between the plans and those providing service as to the fairness of remuneration are to be expected. However, in a sense these are details which, if there is joint negotiation between the plan and those providing service, can be ironed out in due course.

The plans are beneficial for the general public because they provide a broader, more stable, and more equitable basis of financial support for hospital and medical service. Hospital plans increase the ability of communities to support hospital facilities; undoubtedly medical plans if they achieve large coverage will increase the ability of communities to support the medical personnel they need.

The usefulness of the plans to the general public must be understood in the light of the fact that the plans have enrolled proportionately more of the well-to-do than of the lower income groups and of urban than of rural people.

The basic formula of the hospital plans -- non-profit status, one plan per area, free choice of hospital and the right of all qualified hospitals to participate, the provision of benefits on a service basis -- is sound and mutually beneficial for patients and hospitals. The prevailing pattern of the medical plans -- non-profit status, one plan per area, free choice of physician, and the right of all qualified physicians in the area to participate -- is also good. The medical plans will not be as useful to the public as the hospital plans until they provide their benefits on a service basis.

In general and with some exceptions the plans are well conducted and efficiently administered.

The plans with their large enrollments are rendering an important contribution to the health and security of the population and those responsible for this development -- a truly amazing one -- have every reason to be proud of their accomplishments.

HOW THE PLANS COULD BE IMPROVED

The plans could be made more useful to the public -- and also to hospitals and physicians -- in various ways. Since, at the request of the Blue Cross plans, one objective of the survey was to ascertain how the plans might serve the public more effectively, what follows may be considered as a series of suggestions to this end.

COMPREHENSIVE SCOPE OF SERVICE

The plans would be more useful to the public if they provided a more comprehensive service. The hospital plans are very uneven in the degree of coverage of the hospital bill. Some plans (alone or in conjunction with the allied medical plan) give virtually complete protection. The subscriber if he takes the accommodations specified in the contract will have little or nothing to pay. Other plans provide a coverage which is full of gaps. The subscriber who requires prolonged care, or expensive medication, or large amounts of the special services, will have a large bill to pay. Since the public has to meet the cost of complete hospital service it follows that the plans would be more useful to their subscribers if they provided this service -- full coverage of the bill for at least 60 or 90 days.

The medical plans are obviously incomplete. With some few exceptions the plans cover only about a third of the total cost of physicians' service. The plans tend to cope with illness only after it has become serious; they do little to prevent illness or to prevent incipient illness from becoming serious through the provision of care in the early stages. Much evidence indicates that the public wants a complete service, and only under such a service will many obtain adequate care. Another factor of importance is that the restricted scope of service leads to hospitalization of patients who could be cared for just as well and more economically in the home, office, or out-patient department.

Even if the plans provided complete hospital service and complete physicians' service they would not fully meet the needs of the public. The cost of special nursing in a serious illness may well exceed the cost of hospitalization, and protection against this cost is urgently needed. Provision of a visiting nurse service on a prepayment basis would in many instances tend to reduce the need for hospitalization and would increase the physician's effectiveness. The provision of dental service on a prepayment basis would enable a large segment of the population to obtain this service who will otherwise go without. In short, the public needs a complete health service on a prepayment basis, and the plans would be more useful if they provided such a service.

The plans, therefore, should move as rapidly as possible to provide a comprehensive service. Such expansion of coverage cannot be achieved overnight. The provision of complete hospital service for, say, 60 or 90 days per admission may not be feasible until controls have been developed to prevent possible abuse. Medical plans need to achieve substantial enrollment for surgical, obstetrical and in-hospital service and to solve the administrative and financial problems of this coverage before going on to the vastly more difficult task of providing coverage for home and office calls. Provision of these latter services will require new administrative techniques and controls, the development of trustworthy utilization data, and a high degree of cooperation from the medical profession. Similarly expansion later to nursing and dental care will present new and complicated problems which can only be tackled one at a time. While the public wants comprehensive coverage it is unfamiliar with the costs involved and at each stage it must be educated to pay the necessary subscription costs. However, while recognizing the practical difficulties involved the plans should take as their goal the provision of comprehensive service, and step by step as rapidly as possible should move to attain this goal.

BENEFITS ON A SERVICE BASIS

The plans would be more useful to the public if they provided their benefits entirely on a service basis.^{2/} Indemnity allowances against hospital and physician charges cannot provide an assured, definite or complete protection since there is no obligation on the part of hospitals or physicians to render service at specified remuneration. It follows that those hospital plans which provide dollar allowances against the room cost or against the cost of certain of the special services or both would be more useful if they provided care in specified accommodations and gave complete coverage of the special services. The medical plans would be more useful if they extended

^{2/} But permitting the subscriber to pay extra in order to receive care in better hospital accommodations than are specified in the contract.

service benefits to all subscribers irrespective of income. Again the practical difficulties are recognized. These steps will require a high degree of cooperation on the part of hospitals and physicians; they will require important changes in the prevailing usages of medical practice; they may possibly necessitate differential remuneration as between qualified specialists and non-specialists for services in certain specialty fields. However, the plans would do well to accept the goal of benefits on a full service basis.

PROVISION OF CARE FOR ALL CONDITIONS OF ILLNESS

The plans would serve the public more effectively if, under appropriate enrollment procedures, care were provided for all conditions of illness without exception or waiting period. The exception of care for quarantinable diseases, venereal disease, congenital defects, alcoholism, drug addiction and the like which exist in the contracts of many plans are generally but inheritances from the past and could now be eliminated without danger to financial soundness and at very little increase in cost.

The exception of care for infants under certain ages which some plans still hold to is quite undesirable and could be safely eliminated. That the administrative problems involved are not insuperable is evidenced by the fact that many plans do provide coverage from the first day of birth.

The waiting period for maternity care is necessary under individual enrollment. Under group enrollment where the plan is in a position to insist upon high enrollment percentages -- and most well established plans are -- the waiting period can be safely eliminated. Hospital plans which obtain good enrollment percentages can safely provide full benefits in maternity cases at least for a specified number of days. Since limits on the days of coverage for maternity cases work a hardship in those exceptional cases where a longer than normal stay is medically necessary, the plans would do well to experiment with controls which would permit longer coverage for maternity care in the exceptional case.

The exclusion of care for pre-existing conditions is necessary under individual enrollment but is not necessary under group enrollment at least where the plan is in a position to insist on high enrollment percentages. Some plans now are probably spending as much, if not more, on administrative procedures for the rejection of cases of pre-existing conditions, than it would cost them to provide the care for these conditions. Needless to say the elimination of this restriction would improve public relations.

The medical plans tend to have more exclusions and waiting periods than the hospital plans. In view of the newness of these plans these safeguards may perhaps be necessary. However, the plans would be improved if, as rapidly as possible, they eliminated these restrictions.

Coverage of mental disease and tuberculosis presents problems the solution of which will require coordination of the activities of the plans and of public agencies. There is an increasing tendency for both mental and tuberculosis cases to be accepted by general hospitals for diagnosis and certain types of therapy and it is generally agreed that such a tendency is desirable. While it would seem that the plans should cover such illnesses for a restricted period, it is not clear that it would be desirable for the plans to provide coverage for extended periods lest in so doing they assume cost burdens which are now carried to a large extent by public agencies.

RIGHT OF ALL QUALIFIED HOSPITALS AND PHYSICIANS TO PARTICIPATE

All qualified hospitals and physicians should have the right to participate in these plans. The exclusion from participation of any qualified hospital or physician or group of hospitals and physicians may work severe damage upon those so excluded and may be undesirable from the standpoint of denying to the public a proper freedom of choice. These plans when they become large take on the character of public utilities. The decision as to what hospitals or what physicians may participate should preferably be made by a public body under legislative direction, not by the plan. Thus, where there is licensing of hospitals, all licensed hospitals should have the right to participate. Similarly all licensed physicians should have the right to participate. The provision in some medical plans that participation shall be limited to members of the medical society is undesirable.

PLANNING FOR HEALTH FACILITIES

The plans would serve the public more effectively if they assumed greater responsibilities with respect to the planning and development of adequate health facilities in their areas. The plans have a manifest interest in the availability of adequate hospital facilities. Unless such facilities exist, unless subscribers can gain entrance to hospitals when care is needed and can stay as long as may be medically desirable, the plans in effect cannot live up to the terms of their subscriber contracts, i.e., provide service as needed. In rural areas without adequate hospital facilities the plans will find it impossible or difficult to sell their contracts. The plans have no less an interest in seeing to it that there is no excess of hospital facilities, for such an excess resulting in low occupancy ratios will ultimately be reflected in higher per diem hospital costs and hence higher subscription charges. It follows that the plans should take steps in company with public agencies, the hospitals, the medical profession and other interested parties to see to it that their areas possess adequate, well coordinated, hospital facilities.

Medical plans, when they become well established, ought to assume responsibilities along the same lines. Any lack of physicians in rural areas will prevent the plans from functioning effectively in these areas. Any excess of physicians in urban areas may well be prejudicial to the best interests of the subscribers. Well established plans need to concern themselves with these matters and to work with others in finding appropriate solutions.

ASSUMPTION OF RESPONSIBILITY FOR QUALITY OF SERVICE AND THE EFFICIENT PROVISION OF SERVICE

Hospital and medical plans are or ought to be more than devices for paying hospital and medical bills. They are -- when they are on a service basis -- cooperative arrangements of the public and those providing service for the provision of service to the public. This being so they should take steps, in cooperation with hospitals, the medical profession and other interested parties, to see to it that the quality of service provided to their subscribers is good, and that service is provided efficiently and at as low a cost as possible.

A young or small hospital plan is hardly in a position to concern itself effectively with the quality of service provided by its member hospitals. However when a plan has grown to the stage that it is paying to hospitals a third or a half of their income, then inevitably its activities affect the quality of service and it should utilize its central position to elevate standards of service.

Hospital plans, where suitable hospital licensing legislation does not exist, should press for such legislation. Where hospitals are licensed the plans should cooperate closely with the agency in charge to see that proper standards are enforced.

In the absence of hospital licensing the plans should draw up definite standards for hospitals to be accepted as member institutions and these standards should be progressively revised and elevated so that inferior institutions will be obliged to improve their facilities and services.

Where hospitals derive a large share of their income from the plans, the methods and rates of remuneration will have an important effect upon the quality of service -- for better or for worse. The plans should endeavor to remunerate hospitals on a basis which will take quality of service into account, which will, other things being equal, provide higher remuneration to hospitals providing a better quality and more inclusive scope of service, and which will provide incentives to hospitals to improve their standards of service. The basis of remuneration of hospitals should also provide incentives to hospitals to operate efficiently and at low cost. (Uniform cost accounting on the part of hospitals is essential for the determination of fair remuneration.)

The plans should cooperate with the hospitals and the medical profession of the area and other interested parties in bringing about systematic inter-relationships among the hospitals of the area which would make for improved service to the public, good integration of hospital service in the area, and the effective and economical use of hospital facilities.

Medical plans, as they become well established, should do what they can to assure that their subscribers receive service of a high level of quality and that care is provided efficiently and economically. The plans should do what they can to aid subscribers in need of service requiring special skills to obtain such service from qualified practitioners. Many medical leaders believe that group practice has advantages from the standpoint of coordinating the work of different specialists, saving the time of physicians, and making effective and economical use of auxiliary personnel and of facilities and equipment. If this is so, medical plans as they become firmly established would increase their usefulness if they promoted the establishment of diagnostic centers and the development of group practice among their participating physicians.

SUBSCRIPTION COSTS IN RELATION TO ABILITY TO PAY

The subscription costs of the plans are beyond the reach of a part of the population. One way in which hospital plans can achieve greater enrollment among low income groups is for those plans, which do not now have such contracts, to offer low cost contracts providing care in ward or multiple bed accommodations. Some of the plans have offered such contracts in the past with but little success. The reasons for this apparently were that since these contracts provided care in accommodations which did not permit the subscriber to have his own physician and since the character of the accommoda-

tions were in no wise different from those of free wards, the plans were in effect endeavoring to sell low income subscribers something which they could readily obtain free of charge. The conditions for successful sale of these contracts would seem to be that they should provide care in accommodations in which the subscriber can have his private physician and which are otherwise sufficiently differentiated from free wards so that people will have an incentive to enroll. In some areas the successful sale of such contracts will require the development by hospitals of what is essentially a new type of hospital accommodations.

Another step which the plans could take to make their services more available to those of low income is to do their utmost to encourage arrangements under which the employer pays part or all of the cost. Where the employer pays only part of the cost, arrangements under which the employer would pay more of the cost for the lower than the higher paid employees, would seem to be desirable.

ADEQUATE PUBLIC PARTICIPATION IN CONTROL

The public should have a greater voice in the control of these plans. This is especially true in the case of the medical plans. The fundamental question here is "For whom do the plans exist?" If the primary purpose of the plans is to serve the public then it follows that the public ought to have a large, probably a dominating, share in their control.

Adequate representation of the public is necessary from the standpoint of safeguarding the public interest. If hospitals control the plans then hospitals can determine how much they should be paid for their services. This is something on which the public should have a say. If the medical profession controls the plans then the profession determines what physicians shall be paid for their services. A non-profit plan controlled by representatives of those practicing medicine for profit would seem to be a contradiction in terms. Imagine that these plans grow as their sponsors hope and that they displace all competing plans. In effect they would have a monopoly in their area. In this event hospitals and physicians, if they controlled these plans, could fix their own remuneration and the public would have to pay these rates or go without the benefit of prepayment. Such a situation would be intolerable.

However, the matter is not simple. The guarantee of benefits by the participating hospitals and physicians is enormously valuable to the subscribers. In most cases, the plans could not have been established without this guarantee. So long as hospitals and physicians guarantee the benefits they would seem to be entitled to a large, if not a predominant, share in control. A situation under which the plans were controlled by representatives of the subscribers, and hospitals or physicians were liable to make up any deficit, as it were, would seem untenable. One may draw the conclusion therefore that in the initial stages, when a plan's major assets are the backing and support of its participating hospitals or physicians, it would be appropriate for dominant control to rest with the hospitals or the medical profession as the case may be. However, as the plan develops, as it accumulates a substantial reserve (which belongs to the public) and thus guarantees its own financial solvency, then it would seem appropriate that control should be shared equally between the public and those providing service or that dominant control should be vested in the public.

It follows from all this that the share given to the public in most of these plans, especially the medical plans, should be greatly increased. In a well-established plan which looks largely to its own reserve for its financial solvency it would seem that at least half of the board should be composed of representatives of the public. To the greatest possible extent these individuals should be selected so that they will really represent the public. Employers, labor and farm organizations might well be given representation. The plans would also do well to develop subscriber or member councils as a means of securing two-way communication between the plan and those whom it serves. The plans might well consider whether effective and democratic representation of the public would be improved by having some or all of the public representatives appointed by the governor of the State (in the case of a State-wide plan) or the mayor or city council of the principal city of the area (in the case of a local plan). Effective representation of the public and coordination of the plan's own program with the general health services of the area might also be obtained by having the State or local health officer serve as an ex-officio member of the board.

Hospitals and the medical profession need to be far sighted and unselfish about these plans. It falls to them generally to start these plans, to sponsor them, to guarantee the benefits. But they should perform these services in trust as it were for the public and in due course should cede major control to the public.

Such action on the part of the hospitals and the medical profession involves correlative action on the part of public groups. Control cannot be shared with a vacuum. Employers, labor, farm and other public groups, if they wish to participate in the control of these plans must work with them, take steps to forward their growth, and in general assume the obligations and responsibilities that go along with participation in control. The plans, whatsoever the formal basis of their control, are responsive to public pressure and in a sense the public of any area will have as good a plan as it deserves.

If the views expressed above are correct it follows that those enabling acts which stipulate that a majority of the boards of hospital or medical plans must consist of representatives of the hospitals or of the medical profession, as the case may be, should be changed.

GUARANTEE OF BENEFITS; A NATIONAL POOL OF RESERVES

The financial soundness of the plans should be assured through the plans having adequate reserves or by guarantee of benefits on the part of those providing service, or both. At the present time there are probably some plans which do not have large reserves and which are not firmly backed by the hospitals or the medical profession. Until these plans have adequate reserves they should seek the financial backing of their member hospitals or participating physicians.

The plans would be more useful to the public if they developed an arrangement for a national pool of reserves. Many of the hospital plans appear to be passing beyond the stage at which it is feasible for the hospitals to guarantee their solvency. In effect most of the hospital plans are relying on their own reserves to assure financial soundness. This being so the plans could increase their individual and collective security and at the same time use less income for additions to reserves if they developed a national pool of reserves. This arrangement should be such that each plan would cur-

rently put into the pooled reserve a definite fraction of its gross income. The national organization of the plans should conduct periodic financial audits of each plan and should prescribe the minimum reserves to be maintained by each plan on its own account. A plan which was forced to call upon the national pool for aid would agree that the latter should conduct its affairs until the plan was no longer in debt to the national pool.

The medical plans are certainly not ready for this step. However the hospital plans are ready and should lead the way.

INCREASE IN THE EFFECTIVENESS OF INDIVIDUAL PLANS

There are certain hospital and medical plans which have not grown rapidly or have grown less rapidly than they should. There are other plans which have displayed fair growth but use for administration proportions of income far in excess of the average.

These plans manifestly ought to be improved. In the case of some hospital plans the poor record has been due to inadequate support and backing from the hospitals of the area -- not being effectively sponsored by the hospitals the plans have had difficulty in establishing themselves in the mind of the community as a community agency, not being financially backed by the hospitals they have had to accumulate large reserves to assure financial solvency and hence have not been able to offer liberal benefits. Similarly in the case of some medical plans the poor record has been due primarily to inadequate support and backing from the medical profession. In other instances the lack of rapid growth has been due primarily to the fact that the plans have not had aggressive, alert leadership. In some cases plan directors and boards steeped in complacency and lacking in vision have not been greatly interested in increasing enrollment. Some plans have handicapped themselves by offering too restricted or too complicated a contract. Some plans have carried caution to excess and in endeavoring to accumulate large reserves have asked too much for too little.

In a considerable number of instances the plans with poor enrollment records have been serving areas which are too small in size or population to permit effective operation. Obviously the public would be better served if these plans were merged with others. In North Carolina the competition between the two State-wide plans results in high administrative costs, dissipates the support of the public, the hospitals and the medical profession, and retards growth. The two plans obviously should be merged.

In certain States the hospital plans have not done well or as well as they could because there are too many plans. Their varying rates and benefits make it inconvenient for employers with plants scattered over the State and impede promotional and enrollment efforts. In almost all cases in States with more than one plan the effectiveness of the movement would be increased by merger of some plans and in some cases by merger of all of the plans into a single State-wide plan.

In States such as New York, Pennsylvania, Ohio where the State has several rather distinct hospital service areas, local plans may have done better in the past than a single State-wide plan would have done. However, as time goes on the advantages which local plans obtain through their restriction to a local area tend to grow less, while the disadvantages of having a multiplicity of plans increase. In most if not all States with multiple plans the time has arrived or is rapidly arriving when the public would be better served by a single State-wide plan. The matter of the appropriate

basis for a hospital or medical plan is greatly affected by the need for coordination between the two types of plans and close coordination requires that allied plans serve the same areas.

The fundamental drive for improvement of the individual plan must come from within the area. In general a plan will be as good as the public, the medical profession, and the hospitals of the area want it to be. However, the central organizations of the plans could do much to stimulate local action by making periodic appraisals of each plan and by making the reports of this appraisal available to the plan and the public, the hospitals and the medical profession of the area. Factors in the administration or situation of the plan which need correction and are holding it back might thus be brought out in the open and if so there is a better chance that the parties concerned will take the necessary action.

COORDINATION OF HOSPITAL AND MEDICAL PLANS

In certain instances the progress of hospital and medical plans has been impeded by lack of coordination between the two. In Washington, Oregon and northern California the competition between the Blue Cross and medical plans has been damaging to both types of plans and has lessened their service to the public. In Pennsylvania it is unfortunate that the state-wide medical plan and the local hospital plans have not as yet been able to reach a mutually satisfactory basis of cooperation.

The first requisite of good coordination between hospital and medical plans is that both should serve the same territory. In some States this will mean that the local hospital plans will need to be merged or federated into a single state-wide plan. In Washington and Oregon the local medical plans will need to be merged into a single state-wide plan. The least that is required for effective coordination of the two types of plans is their joint administration by a single staff under a single executive director. Any other arrangement is apt sooner or later to result in friction and trouble.

At the present stage of developments, while medical plans are young and need to win the cooperation and backing of the medical profession, there may be advantages to having hospital and medical plans organized as separate corporations, but with both administered by the same staff under a single executive director. However, this is temporary and in due course -- after medical plans have achieved large enrollment and a secure financial footing -- the two types of plans should be merged. The fortunes of the two types of plans are inevitably bound together; they will succeed or fall together; the one cannot avoid responsibility for the other. The public which pays its money to one organization generally considers the plans as one. This being so they ought eventually to be unified.

Unification of the plans at the local level will inevitably bring unification of the two central organizations of the plans. It will hardly be logical for the resulting single central organization to operate under the aegis of either the American Hospital Association or the American Medical Association. Its board should contain representatives of the plans, the public (employers, labor, farm organizations, etc.), the hospitals and the medical profession.

ENROLLMENT AVAILABLE TO ALL

No plan can adequately serve the public unless it extends the opportunity of enrollment to all persons in its area. Those plans which have not as yet developed devices of individual and community enrollment through which

they are able to offer enrollment to all within their area should do so. Age restrictions are not necessary in group enrollment and should be eliminated by those plans which still retain these restrictions. Age restrictions are necessary under individual enrollment unless this is conducted through community enrollment in such manner that the plan safeguards its selection of risks.

GREATER NATIONAL COORDINATION

To be of maximum service to the public the plans need a far greater degree of national coordination than they now possess. In fact the achievement of a greater degree of national coordination is one of the chief problems now facing the plans.

From the standpoint of serving national employers or national unions (under industry wide bargaining agreements) the plans are handicapped by the lack of uniformity in benefits and rates, in conditions for which care will be provided, and in enrollment procedures, billing procedures and the like. Instead of dealing with a multiplicity of plans, with different (and changing) rates and benefits, these concerns or these unions would prefer to deal with a single organization which at a specified charge would provide uniform benefits for all employees or members wherever located.

From the standpoint of serving the nation as a whole, a defect of the movement is that in certain places no plans exist, and that some of the plans are backward, that they offer restricted benefits, are poorly administered, or are otherwise deficient in the service offered to the public.

The hospital-medical plan movement can hope to meet the public's need for prepayment only if there are available to the people of every area of the country acceptable plans -- plans which provide a reasonably broad scope of service at reasonable costs, which are economically and effectively administered, financially sound and whose activities are well coordinated with each other.

To meet this need the plans (hospital and medical) must develop a far stronger national organization than they now possess. And to this national organization the plans must yield some measure of their autonomy. The plans cannot hope to meet this challenge if they remain merely an association of sovereign, independent plans, each of which is a law unto itself. They must, somehow, somehow, weld themselves into a national movement -- one in which the individual plans will retain a large measure of autonomy, but wherein the national organization, i.e., the movement as a whole, will have sufficient control over the separate plans so as to assure that they measure up to appropriate standards of public service, and that there is the necessary coordination of action among them.

The development of the hospital-medical plan movement into a strong national movement cannot be accomplished merely by the plans themselves. Just as the development of a strong health service plan at the local level will require the cooperation of the public, the hospitals, the medical profession (and, as other services develop, of other professional groups) so the building of a strong national movement will require the cooperation of all these parties.

ENROLLMENT POTENTIALITIES

How far can the plans go in enrolling the population? Will the plans, in conjunction with other types of voluntary insurance, be able within a reasonable period of time to enroll all those who need the benefit of prepayment, i.e., substantially the entire population? The hospital plans have now enrolled (as of Jan. 1, 1947) 24,250,000 persons or 19.3 percent of the population. (Commercial insurance companies and other prepayment organizations provide hospitalization coverage to an additional 12 percent of the population.) During 1946 the hospital plans had a net increase in enrollment equal to 4.2 percent of the population. At this rate of growth it would take them approximately 20 years to enroll the whole population.

As of January 1, 1947, in one State 66 percent of the population had been enrolled. In two other States the plans had enrolled close to 50 percent of the population and in six other States over 30 percent.. In these and a few other States the plans during 1946 were enrolling people at rates which if continued would result in the enrollment of a substantial part of the population, say, 70 to 80 percent, within five to ten years.

On the other hand in many States particularly in the South the plans have enrolled but a small part of the population and are making but little headway. At 1946 rates of growth it would take over 80 years for the plans in Georgia, Alabama, Texas and Louisiana to enroll the whole population of these States.

Medical prepayment is obviously in its infancy and the present growth of total enrollment gives little clue to future potentialities. In certain allied hospital and medical plans enrollment for medical benefits is rapidly approaching enrollment for hospital benefits. If medical plans place their benefits on a service basis and if the two types of plans are unified, it would seem that in due course medical prepayment would attain the same enrollment as hospital prepayment.

The main obstacle to complete enrollment of the entire population is the fact that a part of the population cannot afford the subscription costs. Comprehensive coverage of hospital and physicians' services -- not to mention dentistry and nursing -- might well entail costs of \$2.50 to \$3.50 a month for a single individual, \$5.00 to \$7.00 a month for a couple, and \$6.00 to \$10.00 a month -- \$72 to \$120 a year -- for a family. When one considers that in 1945, 79 percent of all single individuals and 34 percent of all families had money incomes of less than \$2,000 a year,^{3/} and that on the average people spend about five percent of income for all medical care, including drugs, dentistry and nursing (expenditures for physicians' service and hospital care represent about 50 to 60 percent of the total), it is obvious that these costs will be beyond the reach of a substantial part of the population.

Another important obstacle to enrollment of the entire population is the fact that many who could afford prepayment will not readily avail themselves of the plans because of inertia, indifference and lack of appreciation of their need for prepayment. Through their enrollment campaigns the plans educate the public to the need for health protection, but these campaigns are necessarily limited. Still another obstacle is the difficulty of reaching and enrolling farm people, the self-employed and people who work in small employed groups.

^{3/} Bureau of the Census, *Family and Money Income in the United States: 1945 and 1944*; Series P-S, No. 22, May 8, 1947, p. 7.

In the lights of these factors it is evident that the plans will not be able to enroll the entire self-supporting population, though in some States they may make appreciable headway in this direction. In short, while the plans are potentially capable of making large contributions towards health security, by themselves they will not be able to solve the entire problem.

Leaders of hospital and medical plans have recognized this and have stated their interest in cooperating with governmental agencies in the provision of health services for those unable to pay for such care.^{4/} The Blue Cross plans have suggested Federal grants-in-aid to State approved voluntary plans^{5/} and some Blue Cross leaders have suggested that government might require certain groups of the population to enroll in prepayment plans, people being free to select the plan of their choice.^{6/}

It is quite clear that these and other courses of action on the part of government would enable voluntary plans greatly to increase their enrollments. The findings of the survey suggest that the question -- of how the plans might be used, supplemented or built upon in a governmental program or in a cooperative program of government and voluntary plans -- is one that deserves an increased measure of attention.

^{4/} At the October 1945 Conference the Blue Cross plans adopted the following resolution:

"If the Federal government decides to use government funds for the payment of hospital service for those unable to pay for such service, the committee on government relations (should) express to the proper authorities the willingness of Blue Cross to participate with such authorities in working out practical methods of cooperation."

^{5/} In testifying on the Wagner-Murray-Dingell Bill (S. 1606) before the Senate Committee on Education and Labor the authorized representative of the plans stated:

"The Blue Cross Commission favors the following approach to a health program for the American people:

(a) Complete medical care and hospitalization supported by taxation for all public assistance

(a) Complete medical care and hospitalization supported by taxation for all public assistance beneficiaries or indigent members of the population. (This feature is title 1, part C, of Senate Bill No. 1606.)

The provision of health service as a right to those already receiving assistance would clarify the position of charitable organizations in the health field particularly community hospitals. Acceptance by Government for care of the officially declared indigent would permit voluntary plans to remove this burden from member hospitals, and hence from subscribers.

size or the composition of the public. (This feature has been recommended by the President and is included in Senate Bill No. 191.)

Adequate facilities are a requirement of adequate care. Voluntary plans would increase in usefulness with the better distribution of hospitals and other health facilities.

(c) Grants-in-aid to State-approved voluntary health programs which are also supported by regular contributions from the beneficiaries. Payments might be made to practitioners or institutions, or to prepayment plans under non-profit auspices.

Such Government assistance would encourage enrollment and have much the same result as legislative compulsion, but with freedom for localities to determine the timing and character of their health program.

(d) Permissive pay-roll deduction for Federal employees for participation in voluntary prepaid health-service programs.

It might appear that this is a small portion of our population, and not a significant factor in developing a program for the country. Yet, this large group of people should be entitled to the same conveniences in obtaining prepaid health-service benefits as the rest of the workers in the Nation. Moreover, the prestige of the National Government, in recognizing the individual's right to participate on the voluntary basis, would be a strong and encouraging example to those private employers, as well as to the States and local governments, which have not yet seen fit to provide permissive pay-roll deductions for their own employees." (Testimony of C. Rufus Rorem, Hearings before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606, A Bill To Provide for a National Health Program (1946) Part 2, p. 965.)

^{6/} Mr. Louis H. Pink, the president of the New York City Blue Cross plan, has made a proposal to the effect that employers might be required to insure their employees for certain health benefits. In the case of the low income group the State and local governments would divide the cost with the employer; in the case of the middle income group the cost would be divided between the employer and the employee -- each paying one-half; in the case of those with higher incomes, the employee would bear the whole cost. The employer would be permitted, presumably with the approval of the majority of his employees, to take out the insurance with any organization providing the specified benefits. Blue Cross plans, medical plans, insurance companies, company medical service programs and other types of prepayment plans could all participate. (A Health Plan for the State of New York, Published by the Associated Hospital Service of New York, 1946.)

APPENDICES

APPENDIX A

LIST OF APPROVED BLUE CROSS PLANS IN THE UNITED STATES, JANUARY 1, 1947, GIVING ADDRESS OF PLAN AND NAME OF EXECUTIVE DIRECTOR

ALABAMA

Hospital Service Corporation of Alabama
2119 First Avenue, North
Birmingham - 3
Ed. S. Moore, Manager

ARIZONA

Associated Hospital Service of Arizona
414 Arizona Title Building
Phoenix
L. Donald Lau, Executive Director

CALIFORNIA

Hospital Service of Southern California
743 South Grand View Street
Los Angeles - 5
Ralph G. Walker, Executive Director
Hospital Service of California
360 Fourteenth Street
Oakland - 12
J. Philo Nelson, Director
Intercoast Hospitalization Insurance
Ass'n.
1127 "J" Street
Sacramento - 14
Philip A. Stitt, General Manager

COLORADO

Colorado Hospital Service
810 Fourteenth Street
Denver - 2
Joseph R. Grant, Executive Director

CONNECTICUT

Connecticut Hospital Service, Inc.
152 Temple Street
New Haven - 2
Robert Parnall, General Manager

DELAWARE

Group Hospital Service, Inc.
902 Orange Street
Wilmington - 99
Harold V. Maybee, Managing Director

DISTRICT OF COLUMBIA

Group Hospitalization, Inc.
Transportation Building
Washington - 6
E.J. Henryson, Director

FLORIDA

Florida Hospital Service Corporation
P. O. Box 1798
Jacksonville - 1
H.A. Schroder, Executive Director

GEORGIA

United Hospitals Service Association
134 Peachtree Street, N.W.
Atlanta - 3
C.J. Anderson, Executive Director

GEORGIA (Continued)

Hospital Service Association of Savannah
Realty Building
Savannah
H.B. Coolidge, Executive Director

IDAHO

Idaho Hospital Service
205 Jefferson Building
Boise
R.T. Jones, Executive Director

ILLINOIS

Group Hospital Service of Illinois
First National Bank Building
Alton
Louis Degenhardt, Executive Director
Blue Cross Plan for Hospital Care
11 South La Salle Street
Chicago - 90
Edson P. Lichty, Executive Director
Associated Hospitals of Danville
623 Temple Building
Danville
John C. Gage, Executive Director
Decatur Hospital Service Corporation
Standard Office Building
Decatur - 12
Frances A. Walker, Managing Director
Central Illinois Hospital Service
Association
Central National Bank Building
Peoria - 2
Paul F. Bourscheidt, Executive Director
Northern Illinois Hospital Service, Inc.
Gas-Electric Building
Rockford
Wm. N. Armstrong, Executive Director

INDIANA

Blue Cross Hospital Service
700 Test Building
54 Monument Circle
Indianapolis
Guy W. Spring, Executive Director

IOWA

Hospital Service, Inc., of Iowa
Insurance Exchange Building
Des Moines - 7
Fredric P.G. Lattner, Executive Director
Associated Hospitals Service, Inc.
522 Trimble Building
Sioux City - 15
O.L. Smith Executive Secretary

KANSAS

Kansas Hospital Service Association, Inc.
Crawford Building
Topeka
Sam J. Barham, Executive Director

KENTUCKY

Ashland Hospital Service Association
Second National Bank Building
Ashland
J.H. Mathewson, Secretary
Community Hospital Service, Inc.
Urban Building
Louisville - 2
D. Lane Tynes, Executive Director

LOUISIANA

Hospital Service Ass'n. of Alexandria
505 Guaranty Bank Building
Alexandria - 1
Wallace E. Franck, Manager
Hospital Service Ass'n. of Baton Rouge
305 Reymond Building
Baton Rouge - 6
T.B. Bennett, Manager
Hospital Service Ass'n. of New Orleans
American Bank Building
New Orleans - 12 -
Edward Groner, Manager

MAINE

Associated Hospital Service of Maine
87 Exchange Street
Portland - 3
Paul A. Webb, Executive Director

MARYLAND

Associated Hospital Service of Baltimore
15 East Fayette Street
Baltimore - 2
J. Douglas Colman, Executive Director

MASSACHUSETTS

Massachusetts Hospital Service, Inc.
38 Chauncy Street
Boston - 11
R.F. Cahalane, Executive Director

MICHIGAN

Michigan Hospital Service
Washington Boulevard Building
Detroit - 26
Wm. S. McNary, Executive Vice President
and General Manager

MINNESOTA

Minnesota Hospital Service Association
2388 University Avenue
St. Paul - 4
Arthur M. Calvin, Executive Director

MISSOURI

Group Hospital Service, Inc.
Argyle Building
Kansas City - 6
F. Kenneth Helsby, Executive Director
Group Hospital Service, Inc.
3617 Olive Street
St. Louis - 8
Elmer F. Nester, Executive Director

MONTANA

Hospital Service Association of Montana
411 - 413 Power Block
Helena
Robert V. Fortune, Executive Director

NEBRASKA

Associated Hospital Service of Nebraska
330 City National Bank Building
Omaha - 2
J.H. Pfeiffer, Executive Director

NEW HAMPSHIRE

New Hampshire-Vermont Hospitalization
89 North Main Street
Concord
R.S. Spaulding, Director

NEW JERSEY

Hospital Service Plan of New Jersey
31 Clinton Street
Newark - 2
J. Albert Durgom, Executive Director

NEW MEXICO

Hospital Service, Incorporated
206 North Tenth Street
Albuquerque
Ralph G. George, Executive Director

NEW YORK

Associated Hospital Service of Capital
District
112 State Street
Albany - 7
Edward R. Evans, Executive Director
Hospital Service Corporation of Western
New York
888 Delaware Avenue
Buffalo - 9
Carl M. Metzger, Executive Director
Chautauqua Region Hospital Service Corp.
Wellman Building
Jamestown
Robert E. Johnson, Managing Director
Associated Hospital Service of New York
370 Lexington Avenue
New York - 17
Louis H. Pink, President
Rochester Hospital Service Corporation
41 Chestnut Street
Rochester - 4
Sherman D. Meech, Managing Director
Group Hospital Service, Inc.
332 South Warren Avenue
Syracuse - 2
J. Campbell Butler, Executive Director
Hospital Plan, Incorporated
5 Hopper Street
Utica
Harold C. Stephenson, Managing Director
Hospital Service Corp. of Jefferson County
23 Paddock Arcade
Watertown
W.M. Heslop, Managing Director

NORTH CAROLINA

Hospital Saving Ass'n. of North Carolina
Chapel Hill
Eugene B. Crawford, Executive Vice
President

Hospital Care Association, Inc.
107 Market Street
Durham
E.M. Herndon, Executive Vice President

NORTH DAKOTA

North Dakota Hospital Service Association
First National Bank Building
Fargo
Donald Eagles, Executive Director

OHIO

Akron Hospital Service
Second National Building
Akron - 8
Robert C. Jenkins, Executive Director
Hospital Service, Inc., of Stark County
214 Brant Building
Canton - 2
R.O. Parker, Director
Hospital Care Corporation
Taft Road at Woodburn Avenue
Cincinnati - 6
James E. Stuart, Executive Vice President
Cleveland Hospital Service Association
1900 Euclid Avenue
Cleveland - 15
John A. McNamara and Michael A. Kelly,
Directors
Central Hospital Service
79 East State Street
Columbus - 15
Ralph W. Jordan, Director
Hospital Service, Inc.
4th Floor, Dauch Building
Lima
Paul J. Lynch, Executive Director
Portsmouth Hospital Service Association
23 National Bank Building
Portsmouth
Edward R. Young, Jr., Director
Hospital Service Association of Toledo
441 Huron Street
Toledo - 4
James H. Smith, Executive Director
Associated Hospital Service, Inc.
Realty Building
Youngstown - 3
Alfred C. Cook, Executive Director

OKLAHOMA

Group Hospital Service
Boston Building
910 South Boston
Tulsa - 3
N.D. Helland, Director

OREGON

Northwest Hospital Service Plan
Terminal Sales Building
Portland - 5
Frank F. Dickson, Executive Director

PENNSYLVANIA

Hospital Service Plan of Lehigh Valley
17 North Seventh Street
Allentown
Allen D. Howland, Assistant Director
Capital Hospital Service, Inc.
200 Locust Street
Harrisburg - 11
Clement W. Hunt, Executive Director

PENNSYLVANIA (Continued)

Associated Hospital Service of
Philadelphia
112 South Sixteenth Street
Philadelphia - 2
E.A. van Steenwyk, Executive Director
Hospital Service Association of Pittsburgh
Farmers Bank Building
Pittsburgh - 22
Abraham Oseroff, Vice President and
Secretary
Hospital Service Ass'n. of Northeastern
Pennsylvania
Bennett Building
Wilkes-Barre
George T. Bell, Jr., Executive Director

RHODE ISLAND

Hospital Service Corporation of Rhode
Island
31 Canal Street
Providence - 3
Stanley H. Saunders, Executive Director

TENNESSEE

Tennessee Hospital Service Association
306 Ochs Building
Chattanooga - 2
John R. Hill, Executive Director
Community Hospital Service
Holston Valley Community Hospital
Kingsport
George W. Eutsler, Director

TEXAS

Group Hospital Service
2022 Bryan Street
Dallas - 1
Walter R. McBee, Executive Director

UTAH

Intermountain Hospital Service
462 Union Pacific Annex
Salt Lake City
D.O. Wight, Executive Director

VIRGINIA

Piedmont Hospital Service Association
Peoples National Bank Building
Lynchburg
Francis I. Libby, Manager
Virginia Peninsula Hospital Service
Ass'n.
Deal Building
Newport News
John B. Locke, President
Tidewater Hospital Service Association
269 Bousch Street
Norfolk
William R. Lowe, Managing Director
Virginia Hospital Service Association
207 East Franklin Street
Richmond
M. Haskins Coleman, Jr., Executive
Director
Hospital Service Association of Roanoke
Colonial-American Bank Building
Roanoke - 8
Leonard O. Key, Executive Director

WASHINGTON

Washington Hospital Service
1119 Fourth Avenue
Seattle - 1
George Doust, Director

WEST VIRGINIA

Hospital Service, Incorporated
203 Atlas Building
Charleston
John Hart, Manager

WEST VIRGINIA (Continued)

Huntington Hospital Service, Inc.
P. O. Box 509
Huntington 9
J.H. Mathewson, Executive Director

WISCONSIN

Associated Hospital Service, Inc.
611 North Broadway
Milwaukee - 2
Leon R. Wheeler, Executive Secretary

APPENDIX B

AREAS SERVED BY LOCAL (NON-STATEWIDE) PLANS

(Data as of Jan. 1, 1947)

STATE AND PLAN	AREA SERVED
CALIFORNIA	
LOS ANGELES PLAN:	Counties of Fresno, Imperial, Inyo, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura.
OAKLAND PLAN:	Counties of Alameda, Contra Costa, Marin, Monterey, San Benito, San Francisco, San Mateo, Santa Clara and Santa Cruz.
SACRAMENTO PLAN:	Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Kings, Lake, Lassen, Mariposa, Mendocino, Merced, Madera, Modoc, Mono, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba; also Washoe county in Nevada.
GEORGIA	
ATLANTA PLAN:	Fulton and DeKalb counties, and a 50-mile radius around Atlanta.
SAVANNAH PLAN:	Bryan, Chatham and Effingham counties.
ILLINOIS	
ALTON PLAN:	Counties of Bond, Calhoun, Clay, Christian, Crawford, Effingham, Fayette, Greene, Jasper, Jersey, Lawrence, Macoupin, Madison, Montgomery, Morgan, Richland, Sangamon (except Springfield), and Scott.
CHICAGO PLAN:	Counties of Cook, Du Page, Kane, Kankakee, Lake, and Will.
DANVILLE PLAN:	Vermilion and Edgar counties.
DECATUR PLAN:	Counties of Clark, Coles, Cumberland, DeWitt, Douglas, Macon, Moultrie, Piatt, and Shelby.
PEORIA PLAN:	Counties of Adams, Brown, Bureau, Cass, Ford, Fulton, Grundy, Hancock, Henderson, Henry, Iroquois, Knox, LaSalle, Livingston, Mason, Marshall, McDonough, McLean, Menard, Peoria, Pike, Putnam, Schuyler, Stark, Tazewell, Warren and Woodford; parts of Logan, Mercer, and Rock Island counties.
ROCKFORD PLAN:	Counties of Boone, Carroll, Dekals, Jo Daviess, Lee, McHenry, Ogle, Stephenson, Whiteside and Winnebago. Also parts of Rock Island and Mercer Counties. Plan also has branch office in Springfield and Champaign-Urbana. Plan enrolls State groups having employees or members throughout Illinois and enrolls other groups in scattered counties throughout the State.
IOWA	
DES MOINES PLAN:	All of Iowa east of, but including, counties of Winnebago, Hancock, Wright, Hamilton, Greene, Audubon, Cass, Montgomery, and Fremont. Audubon County is also served by the Sioux City plan.

STATE AND PLAN**AREA SERVED**

IOWA (Continued)**SIOUX CITY PLAN:**

Counties of Woodbury, Pottawattamie, Lyons, Osceola, Dickinson, Emmet, Kossuth, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Pocahontas, Humboldt, Ida, Sac, Calhoun, Webster, Monona, Crawford, Carroll, Harrison, Audubon, Shelby, and Mills. Plan also serves parts of South Dakota.

KANSAS**TOPEKA PLAN:**

State of Kansas, except Wyandotte and Johnson counties.

KENTUCKY**ASHLAND PLAN:**

Counties of Bath, Boyd, Breathitt, Carter, Elliott, Fleming, Floyd, Greenup, Johnson, Knott, Lawrence, Lee, Letcher, Lewis, Magoffin, Martin, Mason, Menifee, Morgan, Perry, Pike, Powell, Rowan and Wolfe.

LOUISVILLE PLAN:

All of Kentucky west of Mount Sterling in Montgomery county.

LOUISIANA**BATON ROUGE PLAN:**

East Baton Rouge, East Feliciana, Livingston, Pointe Coupee, Saint Helena, West Baton Rouge, and West Feliciana parishes.

ALEXANDRIA PLAN:

Parishes of Allen, Avoyelles, Beauregard, Concordia, Calcasieu, Caldwell, Cameron, Catahoula, DeSota, Evangeline, Franklin, Grant, Jefferson Davis, LaSalle, Matchitoches, Rapides, Red River, Sabine, Saint Landry, Tensas, Vernon, and Winn.

NEW ORLEANS PLAN:

Parishes of Acadia, Ascension, Assumption, Iberia, Iberville, Jefferson, Lafayette, La Fourche, Plaquemines, Saint Bernard, Saint Charles, Saint James, Saint John the Baptist, Saint Martin, Saint Mary, Orleans, Saint Tammany, Tangipahoa, Terre Bonne, Vermilion, and Washington.

MISSOURI**KANSAS CITY PLAN:**

Counties of Andrew, Atchison, Buchanan, Caldwell, Cass, Clay, Clinton, Daviess, De Kalb, Gentry, Harrison, Holt, Jackson, Johnson, Lafayette, Nordaway, Platte, Ray, and Worth; also Kansas counties of Johnson and Wyandotte.

ST. LOUIS PLAN:

State of Missouri, except Kansas City area; also Illinois counties of Alexander, Clinton, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Madison (southern portion), Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, St. Clair, Saline, Union, Wabash, Washington, Wayne, White, and Williamson.

NEW YORK**ALBANY PLAN:**

Albany, Clinton, Columbia, Essex (except around Lake Placid), Fulton, Greene, Montgomery, Renesselaer, Earatoga, Schenectady, Scholharle, Warren, and Washington counties.

BUFFALO PLAN:

Allegany, Cattaraugus, Erie, Genesee, Niagara, Orleans, and Wyoming counties.

JAMESTOWN PLAN:

Chautauqua county.

STATE AND PLAN
AREA SERVED

NEW YORK (Continued)

NEW YORK CITY PLAN:	Greater New York and surrounding territory, including New York, Bronx, Kings, Queens, Richmond, Putnam, Dutchess, Columbia, Rockland, Orange, Ulster, Greene, Sullivan, Delaware, Nassau, Suffolk, and Westchester counties.
ROCHESTER PLAN:	Livingston, Monroe, Ontario, Seneca, Yates, Wayne counties.
SYRACUSE PLAN:	Broome, Cayuga, Chemung, Cortland, Madison (western half), Onondaga, Schuyler, Steuben, Tioga, and Tompkins counties.
UTICA PLAN:	Counties of Chenango, Delaware (shared with New York), Essex (around Lake Placid), Franklin, Hamilton, Herkimer, Lewis, Madison (eastern half), Montgomery (west of Canajoharie), Oneida, Oswego, Oteego, and St. Lawrence.
WATERTOWN PLAN:	Jefferson county.

OHIO

AKRON PLAN:	Ashland, Medina, Portage, Richland, Summit, and Wayne counties; also lower third of Huron county.
CANTON PLAN:	Carroll, Harrison, Holmes, Stark, and Tuscarawas counties.
CINCINNATI PLAN:	Adams, Brown, Butler, Clermont, Clark, Clinton, Darke, Greene, Hamilton, Highland, Miami, Montgomery, Preble, and Warren counties.
CLEVELAND PLAN:	Ashtabula, Cuyahoga, Geauga, Lake, and Lorain counties.
COLUMBUS PLAN:	Athens, Champaign, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Perry, Pickaway, Pike, Ross, Union, Vinton, and Wyandot counties.
LIMA PLAN:	Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, Shelby, and Van Wert counties.
PORTSMOUTH PLAN:	Scioto county.
TOLEDO PLAN:	Defiance, Erie, Fulton, Henry, Huron (upper two-thirds), Lucas, Ottawa, Paulding, Sandusky, Seneca, Williams, and Wood counties.
YOUNGSTOWN PLAN:	Belmont, Columbiana, Harrison, Jefferson, Mahoning, Monroe, Noble, Trumbull, and Washington counties.

PENNSYLVANIA

ALLENTOWN PLAN:	Lehigh and Northampton counties.
HARRISBURG PLAN:	Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster (small section), Lebanon, Mifflin, Montour, Northumberland, Perry, Schuylkill, Snyder, Union, and York counties.
PHILADELPHIA PLAN:	Bucks, Lancaster (eastern part) Chester, Delaware, Montgomery, and Philadelphia counties.
PITTSBURGH PLAN:	Western Pennsylvania, including Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre (western half), Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon,

PENNSYLVANIA (Continued)

STATE AND PLAN	AREA SERVED
PITTSBURGH PLAN (Cont.)	Indiana, Jefferson, McKean, Lawrence, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland counties.
WILKES-BARRE PLAN:	Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming counties.
TENNESSEE	
CHATTANOOGA PLAN:	State except Kingsport area.
KINGSPORT PLAN:	Scott county in Virginia; parts of Sullivan, Greene, Hawkins and Hancock counties in Tennessee; area within radius of approximately 25 miles.
VIRGINIA	
LYNCHBURG PLAN:	Amherst, Appomattox, Bedford (half), and Campbell counties.
NEWPORT NEWS PLAN:	Elizabeth City, Gloucester, Mathews, Warwick, York counties.
NORFOLK PLAN:	Norfolk and Princess Anne counties.
RICHMOND PLAN:	All of Virginia east of but including counties of Highland, Augusta, Nelson, Buckingham, Prince Edward, Charlotte and Halifax, except areas served by Newport News and Norfolk plans.
ROANOKE PLAN:	Allegheny, Bath, Bedford (western half), Botetourt, Franklin, Henry and Rockbridge counties and all counties to the west.
WEST VIRGINIA	
CHARLESTON PLAN:	Boone, Clay, Fayette, Greenbrier, Kanawha, Nicholas, Raleigh, Roane and Summers counties.
HUNTINGTON PLAN:	Cabell, Jackson, Lincoln, Logan, Mason, Putnam, and Wayne counties.

APPENDIX C

ENROLLMENT IN EACH HOSPITAL PLAN AS OF JANUARY FIRST, 1936 - 1947

PLAN	DATE OF FIRST EN- ROLLMENT	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947
ALABAMA APR. 1936	-	-	5,867	21,778	41,697	57,315	67,612	77,887	92,048	102,497	135,644	141,066	174,822
ARIZONA OCT. 1944	-	-	-	-	-	-	-	-	-	-	1,622	19,097	35,432
LOS ANGELES, CALIF. MAR. 1938	-	-	-	-	13,125	21,622	29,438	43,866	46,382	60,415	108,213	137,799	304,735
OAKLAND, CALIF. JAN. 1937	-	-	1,489	9,155	21,420	29,000	39,178	59,000	58,943	64,354	99,095	124,703	196,421
SACRAMENTO, CALIF. JUL. 1932	b/	13,826	20,000	20,000	15,728	19,627	19,616	21,901	22,846	25,063	28,583	34,507	51,933
COLORADO OCT. 1938	-	-	-	-	5,548	23,240	50,202	95,377	170,152	220,706	271,103	314,952	415,757
CONNECTICUT FEB. 1937	-	-	-	13,756	61,021	130,664	184,418	265,332	296,978	346,244	451,000	525,000	650,000
DELAWARE NOV. 1935	b/	5,840	5,840	10,102	13,274	18,823	26,795	44,490	60,017	74,673	97,174	110,557	130,956
WASHINGTON, D. C. JUN. 1934	18,000	34,000	34,000	47,000	50,000	80,000	105,000	145,000	160,000	180,000	208,000	235,000	296,300
FLORIDA JUL. 1944	-	-	-	-	-	-	-	-	-	-	4,329	28,000	73,735
ATLANTA, GEORGIA JAN. 1938	-	-	-	-	11,593	18,879	23,326	26,684	29,671	32,886	35,140	39,388	49,536
SAVANNAH, GEORGIA JUN. 1939	-	-	-	-	-	a/	6,587	9,668	11,531	13,659	15,633	17,448	21,234
IDAH0 JUL. 1946	-	-	-	-	-	-	-	-	-	-	-	-	25,233
ALTON, ILLINOIS JUL. 1938	-	-	-	-	7,810	16,605	24,016	31,486	36,115	47,294	63,528	79,284	99,680
CHICAGO, ILLINOIS JAN. 1937	-	-	-	31,487	85,000	147,412	206,200	332,773	448,214	569,028	729,671	821,092	1,178,584
DANVILLE, ILLINOIS AUG. 1937	-	-	-	475	2,083	3,111	4,360	5,068	5,344	6,606	8,674	9,439	11,760
DECATUR, ILLINOIS JAN. 1938	-	-	-	-	3,642	6,169	9,893	13,653	15,630	19,268	21,437	23,922	30,848
PEORIA, ILLINOIS DEC. 1936	-	-	b/	2,529	6,207	11,674	17,798	30,484	44,231	62,185	80,712	104,016	123,556
ROCKFORD, ILLINOIS MAY 1939	-	-	-	-	-	7,757	28,295	54,183	87,197	148,183	213,441	268,126	326,992
INDIANA SEP. 1944	-	-	-	-	-	-	-	-	-	-	8,281	140,495	224,990
DES MOINES, IOWA JAN. 1940	-	-	-	-	-	-	17,181	42,456	70,000	119,092	180,839	237,091	344,061
SIOUX CITY, IOWA MAR. 1940	-	-	-	-	-	-	a/	a/	18,670	26,330	36,112	47,750	61,010
KANSAS JUL. 1942	-	-	-	-	-	-	-	-	7,519	31,886	72,785	152,071	217,548
ASHLAND, KY. APR. 1936	-	-	2,400	3,010	2,918	5,786	6,493	6,802	6,447	7,084	12,637	13,646	14,610
LOUISVILLE, KY. AUG. 1938	-	-	-	-	4,443	15,019	20,003	33,494	44,316	56,615	89,722	129,103	182,110
ALEXANDRIA, LA. OCT. 1938	-	-	-	-	a/	a/	a/	a/	a/	a/	a/	14,066	16,041
BATON ROUGE, LA. NOV. 1938	-	-	-	-	b/	2,314	3,570	5,610	7,630	9,608	12,000	12,987	14,101
NEW ORLEANS, LA. FEB. 1934	40,000	39,676	32,300	40,134	47,721	56,153	65,560	95,026	115,064	126,622	126,622	104,000	126,477
MAINE NOV. 1938	-	-	-	944	11,922	22,632	36,608	55,468	75,500	106,336	130,617	140,000	190,000
MARYLAND NOV. 1937	-	-	4,205	31,760	55,000	80,000	119,240	162,000	206,089	278,628	332,750	440,575	575,153
MASSACHUSETTS OCT. 1937	-	-	10,591	116,284	221,491	260,200	260,200	348,977	460,046	603,082	965,022	1,431,985	1,991,000
MICHIGAN MAR. 1939	-	-	-	-	-	174,236	330,483	817,699	850,000	1,061,882	1,247,116	1,248,000	1,167,365
MINNESOTA JUL. 1933	24,037	33,090	138,236	244,721	309,216	380,937	447,256	517,467	571,349	606,000	638,119	757,489	929,915
KANSAS CITY, MO. JUL. 1938	-	-	-	14,085	36,423	51,811	67,247	96,386	106,473	111,132	130,617	185,000	217,548
ST. LOUIS, MO. APR. 1936	-	6,230	18,000	51,444	96,344	149,823	222,900	280,555	352,381	470,097	596,802	755,153	929,915
MONTANA FEB. 1941	-	-	-	-	-	-	-	a/	8,064	10,561	14,173	20,717	55,243
NEBRASKA FEB. 1939	-	-	-	-	-	a/	a/	a/	16,505	24,145	40,126	57,636	80,907
NEW HAMPSHIRE DEC. 1942	-	-	-	-	-	-	-	-	2,700	31,203	75,331	125,442	197,249
NEW JERSEY JAN. 1933	10,900	18,977	31,189	111,893	180,057	241,770	340,179	419,204	570,200	651,411	796,633	929,915	1,167,365
NEW MEXICO JUL. 1940	-	-	-	-	-	a/	a/	a/	a/	a/	a/	2,291	8,683
ALBANY, NEW YORK SEP. 1936	-	1,500	10,659	27,041	44,237	55,250	67,772	67,772	93,536	115,042	137,325	181,984	217,548
BUFFALO, NEW YORK JAN. 1937	-	-	-	16,241	48,531	96,893	144,183	197,394	279,760	330,829	370,588	366,590	421,002
JAMESTOWN, NEW YORK FEB. 1937	-	-	-	1,332	3,387	6,875	8,225	10,884	12,793	16,167	20,612	24,514	27,767
NEW YORK, NEW YORK MAY 1935	40,439	209,029	555,894	1,080,661	1,358,409	1,252,753	1,293,062	1,293,062	1,312,590	1,412,978	1,767,307	2,194,256	2,779,811
ROCHESTER, NEW YORK JUN. 1935	23,700	55,032	85,673	109,061	131,427	143,755	178,894	204,059	225,741	253,298	266,274	266,274	313,364
SYRACUSE, NEW YORK JAN. 1936	-	7,872	33,433	66,772	92,565	100,529	115,097	115,097	131,387	151,879	170,544	189,192	231,021

a/ Plan not approved at this time.

b/ Data lacking.

APPENDIX C (Cont'd)

ENROLLMENT IN EACH HOSPITAL PLAN AS OF JANUARY FIRST, 1936 - 1947

PLAN	DATE OF FIRST EN- ROLLMENT	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947
UTICA, NEW YORK	FEB. 1937	-	-	11,848	30,690	51,367	68,983	87,788	94,191	97,958	102,342	108,159	136,049
WATERTOWN, NEW YORK	JUL. 1937	-	-	1,776	2,479	3,708	4,492	5,664	6,227	7,293	9,219	10,972	13,607
CHAPEL HILL, N.C.	DEC. 1935	b/	14,395	36,913	a/	a/	137,861	166,201	187,164	212,616	233,010	257,000	313,000
DURHAM, N.C.	AUG. 1933	b/	25,000	45,628	54,977	54,583	60,162	66,268	69,488	86,169	105,083	118,668	144,544
NORTH DAKOTA	APR. 1940	-	-	-	-	-	8,795	17,564	27,730	31,265	37,217	42,000	52,955
AKRON, OHIO	JAN. 1937	-	-	11,028	21,729	31,641	49,048	70,708	77,787	86,142	101,149	116,686	148,423
CANTON, OHIO	OCT. 1938	-	-	-	1,132	8,550	16,650	28,228	34,876	45,224	82,832	88,723	104,178
CINCINNATI, OHIO	SEP. 1939	-	-	-	-	8,104	88,340	207,113	306,663	447,183	494,378	503,663	639,920
CLEVELAND, OHIO	SEP. 1934	20,000	43,585	80,246	153,931	284,784	415,931	576,586	666,807	765,245	828,125	828,979	970,000
COLUMBUS, OHIO	DEC. 1938	-	-	-	b/	8,304	14,737	33,958	70,807	101,776	133,265	131,685	194,400
LIMA, OHIO	JUN. 1940	-	-	-	-	-	a/	a/	16,748	29,170	35,034	39,565	49,862
PORTSMOUTH, OHIO	JAN. 1939	-	-	-	-	a/	5,422	7,070	6,805	9,532	15,196	18,467	22,768
TOLEDO, OHIO	APR. 1938	-	-	-	10,441	43,106	75,219	121,589	155,722	177,768	210,907	224,918	262,797
YOUNGSTOWN, OHIO	MAR. 1938	-	-	-	12,051	32,653	58,215	93,474	108,578	127,151	160,970	178,683	175,076
OKLAHOMA	MAY 1940	-	-	-	-	-	10,269	18,730	31,137	45,936	85,789	122,261	170,597
OREGON	JUN. 1942	-	-	-	-	-	-	-	37,947	29,556	44,208	50,131	64,019
ALLENTOWN, PA.	OCT. 1935	b/	b/	b/	13,700	20,751	a/	35,331	46,459	61,012	84,811	104,508	139,214
HARRISBURG, PA.	MAR. 1938	-	-	-	6,975	17,127	35,074	55,531	70,418	105,351	146,763	200,575	291,585
PHILADELPHIA, PA.	NOV. 1938	-	-	-	37,035	185,252	274,000	347,142	442,075	550,571	688,829	815,771	1,062,207
PITTSBURG, PA.	JAN. 1938	-	-	-	29,764	143,675	303,123	446,468	525,635	664,175	750,787	851,245	1,047,691
WILKES-BARRE, PA.	DEC. 1938	-	-	-	-	10,731	19,186	30,457	46,534	66,357	91,133	125,177	195,371
RHODE ISLAND	SEP. 1939	-	-	-	-	7,896	28,482	83,425	118,591	184,241	247,349	341,272	463,362
CHATTANOOGA, TENN.	OCT. 1945	-	-	-	-	-	-	-	-	-	-	20,392	102,052
KINGSFORD, TENN.	AUG. 1935	-	6,396	7,616	7,294	8,248	9,192	11,006	17,131	21,340	27,500	27,200	31,665
TEXAS	JUN. 1939	-	-	-	-	b/	b/	a/	70,410	74,189	111,701	139,684	215,660
UTAH	JAN. 1945	-	-	-	-	-	-	-	-	-	-	27,197	75,794
LYNCHBURG, VA.	SEP. 1938	-	-	-	b/	2,304	2,713	4,777	4,560	4,677	5,221	5,769	7,913
NEWPORT NEWS, VA.	MAY 1938	-	-	-	b/	b/	8,028	11,055	12,485	15,573	15,909	16,266	18,334
NORFOLK, VA.	SEP. 1935	b/	5,258	9,213	12,815	17,252	21,412	24,748	26,203	27,763	28,139	31,615	37,142
RICHMOND, VA.	OCT. 1935	128	1,965	7,826	20,031	34,609	43,028	54,954	61,142	65,862	86,236	117,004	155,424
ROANOKE, VA.	OCT. 1939	-	-	-	-	1,030	4,669	12,331	17,454	22,043	32,434	45,052	54,429
WASHINGTON	JUN. 1942	-	-	-	-	-	-	-	b/	15,107	60,000	87,483	93,817
CHARLESTON, W. VA.	JAN. 1933	a/	a/	a/	a/	a/	a/	a/	a/	a/	a/	46,145	57,970
HUNTINGTON, W. VA.	JAN. 1939	-	-	-	-	-	11,163	16,027	18,405	21,691	31,042	33,742	37,068
WISCONSIN	JAN. 1940	-	-	-	-	-	28,525	62,251	94,500	173,360	279,700	420,817	589,200

a/ Plan not approved at this time.
b/ Data lacking.

APPENDIX D

CONTRACT PROVISIONS OF BLUE CROSS PLANS

(Note: See Code and Notes Following Each Table in This Appendix)

TABLE I

Types of Contracts Offered and Definition of Accommodations
December 1, 1946
Data from the Blue Cross Commission

HEADQUARTERS CITY	TYPE OF CONTRACT			CONTRACT DEFINITION OF ACCOMMODATIONS (NUMBER OF BEDS PER ROOM OR DOLLAR ROOM ALLOWANCE) (See Code)	
	PRIVATE	SEMI-PRIVATE	WARD	SEMI-PRIVATE	WARD
BIRMINGHAM, ALA. PHOENIX, ARIZ. LOS ANGELES, CAL. OAKLAND, CAL. SACRAMENTO, CAL.	x	x	x	MIN. (P) 2-4 BEDS \$5.00	N.D. 3 PLUS BEDS 3 PLUS
DENVER, COLO. NEW HAVEN, CONN. WILMINGTON, DEL. WASHINGTON, D. C. JACKSONVILLE, FLA.		x	x	2 \$6.00 N.D. N.D.	N.D. 3 PLUS
ATLANTA, GA. SAVANNAH, GA. BOISE, IDAHO ALTON, ILL. CHICAGO, ILL.	x	x	x	MIN. (P) MIN. (P) 2 2-4	4 PLUS 2-4 (S-P) 5 PLUS
DANVILLE, ILL. DECATUR, ILL. PEORIA, ILL. ROCKFORD, ILL. INDIANAPOLIS, IND.		x	x	2-4 \$3.50 2 \$5.00 N.D.	\$3.50 N.D.
DES MOINES, IA. SIOUX CITY, IA. TOPEKA, KANS. ASHLAND, KY. LOUISVILLE, KY.		x		\$4.75 \$4.75 \$4.00 1-3 \$5.00	
ALEXANDRIA, LA. BATON ROUGE, LA. NEW ORLEANS, LA PORTLAND, ME. BALTIMORE, MD.	x	x	x	\$5.00 \$6.00 (P) \$5.50 (P) 2-4 2-4	\$4.00 \$3.50 (S-P) 5 PLUS
BOSTON, MASS. DETROIT, MICH. ST. PAUL, MINN. KANSAS CITY, MO. ST. LOUIS, MO.		x	x	2-4 2 \$5.00 2 2	N.D. 3 PLUS
HELENA, MONT. OMAHA, NEB. CONCORD, N.H. NEWARK, N.J. ALBUQUERQUE, N.M.		x		\$4.00 2-4 2-4 2-4 2-4	
ALBANY, N.Y. BUFFALO, N.Y. JAMESTOWN, N.Y. NEW YORK, N.Y. ROCHESTER, N.Y.		x	x	N.D. 2-4 N.D. 2-4 \$6.00	4 PLUS N.D.

CODE:

P PRIVATE
S-P SEMI-PRIVATE

W WARD
N.D. NOT DEFINED

MIN. MINIMUM RATE ROOM OF THE TYPE COVERED
IN THE SUBSCRIBER'S CONTRACT.

APPENDIX D - 1 (Continued)

HEADQUARTERS CITY	TYPE OF CONTRACT			CONTRACT DEFINITION OF ACCOMMODATIONS (NUMBER OF BEDS PER ROOM OR DOLLAR ROOM ALLOWANCE) (See Code)	
	PRIVATE	SEMI-PRIVATE	WARD	SEMI-PRIVATE	WARD
SYRACUSE, N.Y. UTICA, N.Y. WATERTOWN, N.Y. CHAPEL HILL, N.C. DURHAM, N.C.		x x x x x	x x x	N.D. N.D. N.D. \$5.00 \$6.00 (P) \$5.00 (S-P)	N.D. \$4.00 \$4.00
FARGO, N.D. AKRON, OHIO CANTON, OHIO CINCINNATI, OHIO CLEVELAND, OHIO		x x x x x	x x x x	2-4 2-4 2-4 2-4 2-3	5 PLUS 5 PLUS 5 PLUS 4 PLUS
COLUMBUS, OHIO LIMA, OHIO PORTSMOUTH, OHIO TOLEDO, OHIO YOUNGSTOWN, OHIO	x	x x x x	x x x	N.D. N.D. N.D. (P) 2 \$6.50	N.D. N.D. 3 PLUS \$5.00
TULSA, OKLAHOMA PORTLAND, OREGON ALLENTOWN, PA. HARRISBURG, PA. PHILADELPHIA, PA.		x x x x	x x x	2 2-6 N.D. MIN.	3 PLUS N.D. N.D.
PITTSBURGH, PA. WILKES-BARRE, PA. PROVIDENCE, R.I. CHATTANOOGA, TENN. KINGSPORT, TENN.		x x x x	x x x	N.D. N.D. \$6.00 2 PLUS	N.D. N.D. 3 PLUS
DALLAS, TEXAS SALT LAKE CITY, UTAH LYNCHBURG, VA. NEWPORT NEWS, VA. NORFOLK, VA.	x x	x x x	x x	\$5.00 2-4 \$4.50 (P) \$4.50 N.D. (P)	\$3.50 N.D.
RICHMOND, VA. ROANOKE, VA. SEATTLE, WASH. CHARLESTON, W. VA. HUNTINGTON, W. VA.		x x x x	x x x	N.D. 2 \$5.00 3-5	3 PLUS N.D.
MILWAUKEE, WIS. SAN JUAN, P.R. VANCOUVER, BRIT. COL. WINNIPEG, MANITOBA MONCTON, NEW BRUN.		x x x x	x x	2-4 NO INFORMATION 2-4 N.D.	N.D. N.D.
TORONTO, ONTARIO MONTREAL, QUEBEC		x x	x	N.D. N.D.	N.D.

CODE: P PRIVATE
S-P SEMI-PRIVATE

W WARD
N.D. NOT DEFINED

MIN.

MINIMUM RATE ROOM OF THE TYPE
COVERED IN THE SUBSCRIBER'S CONTRACT.

APPENDIX D

TABLE 2

GROUP SUBSCRIPTION RATES- MONTHLY

As Reported to the Blue Cross Commission, December 1, 1946

HEADQUARTERS CITY	SEMI-PRIVATE			WARD		
	ONE PERSON	TWO PERSON	FAMILY	ONE PERSON	TWO PERSON	FAMILY
BIRMINGHAM, ALA.*	.90P	1.80P	2.20P	.60	1.20	1.50
PHOENIX, ARIZ.	.85	2.00	2.00	--	--	--
LOS ANGELES, CAL.* (2)	--	--	--	1.10	2.60	3.30
OAKLAND, CAL.* (2)	--	--	--	1.10	2.60	3.30
SACRAMENTO, CAL.* (1)	.90	1.80	2.25	--	--	--
DENVER, COLO.	1.00	1.90	2.25	--	--	--
NEW HAVEN, CONN.	1.10	2.20	2.60	--	--	--
WILMINGTON, DEL.*	1.00	1.90	2.25	.65	--	1.35
WASHINGTON, D. C. (1)	.65	1.50	1.75	--	--	--
JACKSONVILLE, FLA.	--	--	--	.80	--	2.00
ATLANTA, GA.	.90P	1.60P	2.15P	.70	1.30	1.75
SAVANNAH, GA.	.90P	1.75P	2.35P	.70SP	1.35SP	1.85SP
BOISE, IDAHO	--	--	--	1.00	2.00	2.50
ALTON, ILL. (1)	.75	1.25	1.50	--	--	--
CHICAGO, ILL.	.90	2.50	2.50	--	--	--
DANVILLE, ILL.	.75	1.50	2.00	--	--	--
DECATUR, ILL.	.75	1.50	2.00	--	--	--
PEORIA, ILL.	1.00	--	2.25	--	--	--
ROCKFORD, ILL.	.65	1.30	1.30	--	--	--
INDIANAPOLIS, IND.	1.00	--	2.50	.80	--	2.00
DES MOINES, IA.	1.20	2.40	2.40	--	--	--
SIOUX CITY, IA.	1.20	2.40	2.40	--	--	--
TOPEKA, KANS.	.85	--	1.75	--	--	--
ASHLAND, KY. (1)	1.00	2.00	2.00	--	--	--
LOUISVILLE, KY.	--	--	--	.65	1.50	1.50
ALEXANDRIA, LA. (2)	1.00	--	2.30	--	--	--
BATON ROUGE, LA.	1.00P	2.00P	2.50P	.60	1.10	1.50
NEW ORLEANS, LA.	1.10P	1.90P	2.40P	.70	1.25	1.65
PORTLAND, ME.*	.85	1.50	2.00	.60	1.00	1.25
BALTIMORE, MD.	.75	1.50	2.00	--	--	--
BOSTON, MASS.*	1.00	2.00	2.50	.60	1.00	1.25
DETROIT, MICH.	1.40	--	3.10	1.12	--	2.60
ST. PAUL, MINN.	1.00	--	2.25	--	--	--
KANSAS CITY, MO. (1)	.75	1.25	1.50	--	--	--
ST. LOUIS, MO.*	1.00	2.00	2.00	--	--	--
HELENA, MONT. (1)	1.00	2.00	2.00	--	--	--
OMAHA, NEB. (1)	1.00	1.50	2.00	--	--	--
CONCORD, N.H.	.85	1.70	2.00	--	--	--
NEWARK, N.J.	.75	2.00	2.00	--	--	--
ALBUQUERQUE, N.M.	.75	1.50	2.00	--	--	--
ALBANY, N.Y.*	.90	1.50	2.00	--	--	--
BUFFALO, N.Y.	1.00	2.25	2.25	.80	1.90	1.90
JAMESTOWN, N.Y.	.65	1.30	1.75	--	--	--
NEW YORK, N.Y.	.80	1.60	2.00	.56	1.32	1.32
ROCHESTER, N.Y.	.80	1.90	1.90	--	--	--
SYRACUSE, N.Y.	.80	--	1.90	--	--	--
UTICA, N.Y.	.70	1.10	1.30	.58	.93	1.10
WATERTOWN, N.Y.	.80	1.60	2.00	--	--	--
CHAPFL HILL, N.C.*	1.00	2.00	2.25	.60	1.20	1.60
DURHAM, N.C.*	--	--	--	SEE NOTE	--	--
FARGO, N.D.	.75	1.50	2.00	--	--	--
AKRON, OHIO	.85	1.75	2.25	.70	1.45	1.85
CANTON, OHIO	1.10	--	2.30	.80	--	1.80
CINCINNATI, OHIO	.95	2.25	2.25	.70	1.75	1.75
CLEVELAND, OHIO	.85	1.70	2.15	.65	1.30	1.65

APPENDIX D- 2 (Continued)

HEADQUARTERS CITY	SEMI-PRIVATE			WARD		
	ONE PERSON	TWO PERSON	FAMILY	ONE PERSON	TWO PERSON	FAMILY
COLUMBUS, OHIO	.90	--	2.25	.75	--	1.90
LIMA, OHIO	1.00	2.00	2.25	--	--	--
PORTSMOUTH, OHIO	1.10P	2.20P	2.75P	.80	1.60	2.00
TOLEDO, OHIO	.90	1.75	2.25	.75	1.45	1.75
YOUNGSTOWN, OHIO	1.15	--	2.30	.90	--	1.80
TULSA, OKLAHOMA (1)	.85	1.50	1.75	.60	1.25	1.50
PORTLAND, OREGON	--	--	--	1.10	2.20	2.95
ALLENTOWN, PA.	.75	1.50	2.00	--	--	--
HARRISBURG, PA.	.85	1.75	2.25	--	--	--
PHILADELPHIA, PA.*	.75	1.50	2.00	.60	1.00	1.25
PITTSBURGH, PA.	.75	1.50	2.00	.60	1.10	1.50
WILKES-BARRE, PA.	.80	1.45	1.90	.50	1.10	1.40
PROVIDENCE, R.I.*	.75	--	1.90	See note for "comprehensive"		
CHATTANOOGA, TENN.	.75	--	1.50			
KINGSPORT, TENN.	--	--	--	.75	1.25	1.50
DALLAS, TEXAS (1)	.90	--	2.10	--	--	--
SALT LAKE CITY, UTAH	1.00	--	2.00	--	--	--
LYNCHBURG, VA.* (1)	.85P	1.55P	2.00P	.40M .60F	1.20	1.40
NEWPORT NEWS, VA. (1)	1.00	1.50	2.00	--	--	--
NORFOLK, VA.*	12.00P	22.00P	41.00P	10.00	16.00	30.00
RICHMOND, VA. (1)	.85	1.50	2.00	--	--	--
ROANOKE, VA. (1)	.85	1.50	2.00	.60	1.10	1.40
SEATTLE, WASH.*	--	--	--	1.25	2.60	3.60
CHARLESTON, W. VA. (1)	1.25	2.00	2.80	--	--	--
HUNTINGTON, W. VA. (1)	1.00	1.50	2.00	--	--	--
MILWAUKEE, WIS.	.90	2.00	2.00	--	--	--
SAN JUAN, P.R.	.75	--	1.50	--	--	--
VANCOUVER, BRIT. COL.	--	--	--	1.00	--	2.00
WINNIPEG, MANITOBA	.95	--	1.85	.75	--	1.25
MONCTON, NEW BRUN.*	.75	--	1.50	.50	--	1.00
TORONTO, ONTARIO	.75	--	1.50	.50	--	1.00
MONTREAL, QUEBEC	.75	1.50	2.00	--	--	--

NOTES

P - Private; SP - Semi-Private; W - Ward; M - Male; F - Female.

(1) \$1.00 enrollment fee.

(2) \$.50 enrollment fee.

* Refer to note below.

BIRMINGHAM, ALA.:	Subscriber and all dependent children: P \$1.30, W \$.90.
LOS ANGELES, CAL.:	One-person female \$1.25.
OAKLAND, CAL.:	One-person female \$1.25.
SACRAMENTO, CAL.:	Rate includes one child only, \$.45 for each additional child.
WILMINGTON, DEL.:	Female subscriber and child(ren) \$1.50.

APPENDIX D- 2 (Continued)

PORTLAND, ME.: Payroll deduction groups of 200 or more representing 75% participation are granted a discount of 20¢ per contract per month from basic semi-private rates.

BOSTON, MASS.: Rates shown are for "comprehensive" contract. Standard contract also offered: one-person \$.85, two-person \$1.65, family \$2.00. See "duration of service" for contract benefits.

CHAPEL HILL, N.C. Semi-private rates shown provide for \$4.00 room. Contract providing for \$5.00 room available at \$1.15 - \$2.30 - \$2.60.

DURHAM, N.C.: Comprehensive certificate sold with daily bed and board allowance of \$4.00, \$5.00, or \$6.00. Rates determined by type of coverage selected.

ALLENTOWN, PA.: Husband and wife contract with maternity benefits \$2.00.

PROVIDENCE, R.I.: "Comprehensive" contract offered at \$1.50 per family with special benefits under special conditions.

LYNCHBURG, VA.: Husband, wife and child: P \$1.85, W \$1.20. Enrollment fee on private-room contract.

NEWPORT NEWS, VA.: Husband, wife and one child \$1.75.

MORFOLK, VA.:

ORGANIZED GROUP RATES - ANNUAL

	EMPL. SUB.	1ST DEP.	2ND DEP.	3RD DEP.	4TH DEP.	5TH DEP.
WARD	\$ 10.00	\$ 6.00	\$ 5.00	\$ 4.00	\$ 3.00	\$ 2.00
PRIVATE	12.00	10.00	7.00	5.00	4.00	3.00

FAMILY RATES - ANNUAL

WARD	\$ 10.00	\$ 8.00	\$ 5.00	\$ 4.00	\$ 3.00	--
PRIVATE	12.00	12.00	7.00	5.00	4.00	--

Additional dependents no additional charge.

SEATTLE, WASH.: One-person female \$1.35, children \$1.00.

HUNTINGTON, W.VA.: Enrollment fee in groups under 100 persons.

MONCTON, NEW BRUN.: (Includes Prince Edward Island, Nova Scotia and New Brunswick)
Changes in subscription rates scheduled for January 1, 1947.

APPENDIX D

TABLE 3
Duration of Service for Contract Benefits For
Medical and Surgical Cases*
(Per Year, Unless Otherwise Specified)
As Reported to the Blue Cross Commission, December 1, 1946

HEADQUARTERS CITY	DAYS OF FULL SERVICE			ADDITIONAL DAYS-DISCOUNT
	FIRST	SECOND	THEREAFTER	
BIRMINGHAM, ALA. PHOENIX, ARIZ. LOS ANGELES, CAL. OAKLAND, CAL. SACRAMENTO, CAL.	21 21 21 21 21	22 25 (PER ILLNESS) (PER ILLNESS) 21	NOTE 30 NOTE	-0- 90-50% 180-50% 180-50% -0-
DENVER, COLO. NEW HAVEN, CONN. WILMINGTON, DEL. DIST. OF COLUMBIA JACKSONVILLE, FLA.	30 21 30 21 31	30 21 30 21 31	30 21 30 21 31	90-50% 90-\$3.00 150-\$2.50 NO LIMIT-10% 90-25%
ATLANTA, GA. SAVANNAH, GA. BOISE, IDAHO ALTON, ILL. CHICAGO, ILL.	21 21 31 30 30	21 25 31 30 30	21 30 31 30 30	DURATION OF ILLNESS-\$1.00 30-25% -0- 180-33 1/3% 90-50%
DANVILLE, ILL. DECATUR, ILL. PEORIA, ILL. ROCKFORD, ILL. INDIANAPOLIS, IND.	21 21 30 21 30	21 21 30 24 30	21 21 30 NOTE 30	344-25% -0- 90-50% 45-\$1.50 30-50%
DES MOINES, IA. SIOUX CITY, IA. TOPEKA, KANS. ASHLAND, KY. LOUISVILLE, KY.	21 21 90 30 21	25 24 (PER ADMISSION) 60 31	30 NOTE 60 31	90-50% -0- -0- 120-50% 69-25%
ALEXANDRIA, LA. BATON ROUGE, LA. NEW ORLEANS, LA. PORTLAND, MAINE BALTIMORE, MD.	30 30 30 21 21	30 30 30 21 21	30 30 30 21 21	90-50% -0- 30-50% 100-50% 60-\$2.00
BOSTON, MASS. DETROIT, MICH. ST. PAUL, MINN. KANSAS CITY, MO. ST. LOUIS, MO.	120 30 30 30 60	(PER ADMISSION) (PER ADMISSION) 30 30 60	 30 30 60	-0- 90-50% 90-50% 180-\$1.50 180-33 1/3%
HELENA, MONT. OMAHA, NEBR. CONCORD, N. H. NEWARK, N. J. ALBUQUERQUE, N. M.	21 30 30 21 30	25 30 30 21 30	30 30 30 21 30	90-50% 120-50% 90-50% 90-\$3.63 90-50%
ALBANY, N. Y. BUFFALO, N. Y. JAMESTOWN, N. Y. NEW YORK, N. Y. ROCHESTER, N. Y.	21 30 21 21 30	42 30 21 (PER ILLNESS) 30	60 30 21 30 30	60-50% -33 1/3% -0- 180-50% 90-\$3.00
SYRACUSE N. Y. UTICA, N. Y. WATERTOWN, N. Y. CHAPEL HILL, N. C.	21 21 21 30	30 25 21 (PER ILLNESS)	30 25 21	60-\$2.00 65-\$2.00 60-\$1.50 60-50%

*Contract benefits for maternity, nervous and mental, tuberculosis, and quarantinable cases are shown in Tables 5 and 6.

APPENDIX D - 3 (Continued)

HEADQUARTERS CITY	DAYS OF FULL SERVICE			ADDITIONAL DAYS-DISCOUNT
	FIRST	SECOND	THEREAFTER	
DURHAM, N. C.	31	(PER ILLNESS)		-o-
FARGO, N. DAK.	21	21	21	-o-
AKRON, OHIO	30	30	30	90-50%
CANTON, OHIO	30	30	30	90-\$3.00
CINCINNATI, OHIO	21	30	30	-o-
CLEVELAND, OHIO	30	30	30	90-w-\$3.00, sp \$3.50
COLUMBUS, OHIO	30	30	30	-o-
LIMA, OHIO	31	31	31	-o-
PORTSMOUTH, OHIO	21	31	31	90-50%
TOLEDO, OHIO	21	31	31	-o-
YOUNGSTOWN, OHIO	21	21	31	-o-
TULSA, OKLA.	30	30	30	150-33 1/3%
PORTLAND, ORE.	21	21	21	90-50%
ALLENTOWN, PA.	21	24	NOTE	49-\$1.50
HARRISBURG, PA.	21	25	31	90-50%
PHILADELPHIA, PA.	21	24	NOTE	60-25%
PITTSBURGH, PA.	21	21	21	90-50%
WILKES-BARRE, PA.	21	25	31	90-50%
PROVIDENCE, R. I.	62	62	62	-o-
CHATTANOOGA, TENN.	21	30	30	90-50%
KINGSFORD, TENN.	21	24	NOTE	21 TO 46-33 1/3%
DALLAS, TEXAS	30	30	30	90-50%
SALT LAKE CITY, UTAH	21	21	21	-o-
LYNCHBURG, VA.	21	21	NOTE	NOT REPORTED
NEWPORT NEWS, VA.	25	25	25	-o-
NORFOLK, VA.	21	25	NOTE	NOTE -25%
RICHMOND, VA.	30	35	35	120-50%
ROANOKE, VA.	21	23	NOTE	NOTE
SEATTLE, WASH.	21	21	21	180-50%
CHARLESTON, W. VA.	42	42	42	-o-
HUNTINGTON, W. VA.	42	42	42	365-NOTE
MILWAUKEE, WISC.	60	60	60	-o-
SAN JUAN, P. R.	21	21	21	69-25%
VANCOUVER, BRIT. COL.	30	30	30	-o-
WINNIPEG, MANITOBA	21	21	21	TO 90-50%
MONCTON, NEW BRUN.	35	35	35	-o-
TORONTO, ONTARIO	31	36	NOTE	-o-
MONTREAL, QUEBEC	21	21	31	-o-

*Contract Benefits for maternity, nervous and mental, tuberculosis, and quarantinable cases as shown in Tables 5 and 6.

NOTES

W- WARD: S-P-BEHI-PRIVATE

BIRMINGHAM, ALA.	One additional day each year thru sixth year, 26 days per year thereafter.
PHOENIX, ARIZ.	Discount days not applicable to nervous and mental. Nervous and mental same as regular full benefit days but only in member hospitals.
SACRAMENTO, CAL.	28 Days third year, 7 additional days each year to maximum of 40, per illness.
WASHINGTON, D. C.	30 Days plus 6 months at 50% if no care used previous year.
SAVANNAH, GA.	Discount only during and after third year of membership.
ALTON, ILL.	Discount to subscriber only.
ROCKFORD, ILL.	27 days third year and 30 days thereafter.
SIoux CITY, IA.	27 days third year and 30 days thereafter.

APPENDIX D - 3 (Continued)

TOPEKA, KANS.	21 days per year to participants 65 and over.
ASHLAND, KY.	25% discount for remainder of contract year.
PORTLAND, ME.	No benefit for 7 days between regular and extended periods. Currently of no effect due to "service dividend".
BOSTON MASS.	Service shown is for "comprehensive" contract. "Standard" contract provides 30 full days plus 90 days at 50% discount.
KANSAS CITY, MO.	Discount period for subscribers and sponsored members only.
ST. LOUIS, MO.	Discount period for subscribers and sponsored members only.
OMAHA, NEB.:	25% discount for family members.
BUFFALO, N. Y.	Discount period remainder of contract year.
UTICA, N. Y.:	42 days first year for fracture cases.
WATERTOWN, N. Y.	Discount period in member hospitals only.
CHAPEL HILL, N. C.	Discount period applies only to room charge. "Comprehensive" contract provides benefit for each separate illness; "ward" contract provides 30 days per "year".
FARGO, N. DAK.	If no care used previous year, subscriber receives 9 additional days each year up to total of 35 days in third year.
AKRON, OHIO	Benefits apply to each calendar year.
TULSA, OKLA.	Discount allowed on basis of private room allowance of \$4.50. Discount period provided only to subscribers.
ALLENTOWN, PA.	27 days third year, 30 days fourth year and thereafter.
PHILADELPHIA, PA.	27 days third year, 30 days fourth year and thereafter.
PITTSBURGH, PA.	Discount period does not include charges for: operating room, anesthesia, laboratory or x-ray. Discount period provided after one year's membership.
WILKES-BARRE, PA.	Benefits shown are for semi-private accommodations. Ward accommodations provide 21 days first year, 24 days second year, 27 days third year, 31 days fourth year and thereafter. No discount period provided in ward accommodations.
PROVIDENCE, R. I.	"Comprehensive" contract provides 150 full benefit days but no discount period.
KINGSPORT, TENN.	27 days third year, 30 days fourth year and thereafter. Discount benefits provided up to \$150 per person per year.
LYNCHBURG, VA.	31 days third year and each year thereafter if no care used previous year.
NORFOLK, VA.	25 days third year, 30 days fourth year and thereafter. Discount benefits for duration of illness in member hospitals.
RICHMOND, VA.	After the first year 35 days and 5 admissions for any one condition. After first year as many 35 day stays as needed for different conditions. Discount period in member hospitals only and only as a continuation of a 35 day stay. No discount period first year.
ROANOKE, VA.	26 days third year, 30 days fourth year, 35 days fifth year and thereafter; discount period same as full benefit days; ward discount \$2.50, semi-private \$3.50.
HUNTINGTON, W. VA.	Discount period provides all listed benefits except room and board.
VANCOUVER, B. COL.	Additional 60 days in event of bone fracture.
WINNIPEG, MANITOBA	Benefits shown are for "low cost contract". "Semi-private" contract provides 21 days first year, 28 days second year, 31 days third year and thereafter.
MONCTON, N. BRUNS.	Longer term of service contemplated beginning January 1, 1947 Includes: Prince Edward Island, Nova Scotia and New Brunswick.
TORONTO, ONTARIO	41 days third year, 46 days fourth year, 51 days fifth year and thereafter.

TABLE 4

HOSPITAL SERVICES PROVIDED

As Reported to the Blue Cross Commission, December 1, 1946

(Dependents receive the same benefits as the subscriber unless otherwise indicated in the notes
All plans provide general nursing service and use of the operating room.)

HEADQUARTERS CITY	BOARD AND ROOM	SPECIAL DIETS	LABORATORY	DELIVERY ROOM*	EMERGENCY ROOM	ANESTHESIA	DRUGS AND MEDICINES	DRESSINGS AND CASTS	X-RAY	ELECTRO- CARDIOGRAMS	PHYSIO- THERAPY	OXYGEN THERAPY	BASAL- METABOLISM	PATHOLOGY	OTHER
BIRMINGHAM, ALA.	X	X	REG.	X	-0-	SUPPLIES	REG.	X(NOTE)	-0-	-0-	-0-	-0-	-0-	-0-	-0-
PHOENIX, ARIZ.	X	X	X	X	X	\$10	X	X	\$15	X	X	X	X	X	BIOLOGY
LOS ANGELES, CAL.	X	X	LTD.	X(NOTE)	\$10	SUPPLIES	LTD.	X	X	-0-	-0-	-0-	-0-	-0-	-0-
OAKLAND, CAL.	X	X	X	X(NOTE)	X	SUPPLIES	ORD.	X	X	X	-0-	-0-	X	X	CYSTOCOPY
SACRAMENTO, CAL.	\$5.00 PER DAY	X	REG.	X	X	\$20	ORD.	X	X	-0-	\$10	-0-	-0-	-0-	AMBULANCE \$10.00
DENVER, COLO.	X	X	X	X	X	\$10	X	X	TC \$15	X	X	X	X	-0-	CYSTOCOPY
NEW HAVEN, CONN.	\$6.00 PER DAY	X	X	X(NOTE)	TO \$7.50	X	X	X	X	X	X	X	X	X	AMBULANCE \$8.00
WILMINGTON, DEL.	X	X	REG.	X(NOTE)	W \$4. SP \$6	-0-	X	X	50%	-0-	-0-	-0-	X	-0-	-0-
DISTRICT OF COLUMBIA	X	X	REG.	X	X	-0-	X(NOTE)	X	-0-	-0-	-0-	-0-	-0-	-0-	-0-
JACKSONVILLE, FLA.	X	X	X	X	TO \$5.00	TO \$10	X	X	TO \$15	-0-	-0-	TC \$25	-0-	X	-0-
ATLANTA, GA.	X	X	\$10	X	-0-	X	\$10	X	-0-	-0-	-0-	-0-	-0-	-0-	-0-
SAVANNAH, GA.	X	X	\$10	X	-0-	-0-	\$10	X	-0-	-0-	-0-	\$10	-0-	-0-	-0-
BOISE, IDAHO.	X	X	X	X	X	X	X	X	X	X	-0-	X	X	-0-	-0-
ALBANY, ILL.	X	X	X	X	\$5	-0-	X	X	X	-0-	-0-	-0-	-0-	-0-	AMBULANCE
CHICAGO, ILL.	X	X	X	X	X	X	X	X	X	X	X	X	X	-0-	CYSTOCOPY
DANVILLE, ILL.	X	X	X	X	-0-	-0-	X	X	X	-0-	-0-	-0-	-0-	-0-	-0-
DECATUR, ILL.	\$3.50 PER DAY	X	X	X	-0-	X	X	X	-0-	X	X	X	X	-0-	-0-
PEORIA, ILL.	X	X	X	X	X	X	X	X	X	X	X	X	X	-0-	-0-
ROCKFORD, ILL.	\$3.50 OP \$5 PER DAY	X	X	X	X	SUPPLIES	X	X	X	-0-	-0-	-0-	-0-	-0-	-0-
INDIANAPOLIS, IND.	X	X	X	X	X	X	X	X	\$15	X	X	X	X	-0-	-0-
DES MOINES, IA.	\$4.75 PER DAY	X	X	X	\$10	\$10 & SUPP. (NOTE)	X	X	\$15 (NOTE)	X	X	X	X	X	-0-
SIOUX CITY, IA.	\$4.75 PER DAY	X	\$15	X	X	\$10	X	X	\$15	-0-	-0-	-0-	-0-	-0-	-0-
TOPEKA, KANS.	\$4.00 PER DAY	X	REG.	X	X	SUPPLIES	REG.	X	-0-	X	X	X	X	-0-	-0-
ASHLAND, KY.	X	-0-	REG.	X	X	SUPPLIES	REG.	REG.	-0-	-0-	-0-	-0-	-0-	-0-	-0-
LOUISVILLE, KY.	\$5.00 PER DAY	X	X	X	X	-0-	X	X	-0-	-0-	X	X	X	-0-	TRANSFUSIONS (NOTE)
ALEXANDRIA, LA.	\$5.00 PER DAY	X	\$20	X	X	X	\$5	X	50%	DIAGNOSTIC	-0-	\$25	X	-0-	-0-
BATON ROUGE, LA.	\$4 OR \$6 PER DAY	X	X	X	X	-0-	X	X	-0-	-0-	-0-	-0-	-0-	-0-	-0-
NEW ORLEANS, LA.	X(NOTE)	X	X	X	X	-0-	X	X	50%	-0-	-0-	50%	50%	-0-	-0-
PORTLAND, ME.	X	X	LTD.	X	\$10	X	LTD.	LTD.	LTD.	LTD.	LTD.	LTD.	LTD.	X	-0-
BALTIMORE, MD.	X	X	X	X(NOTE)	X	X	X	X	X	X	X	X	X	-0-	-0-

(Note) appears in this column, benefits are listed under section entitled "Contract Benefits for Maternity Cases."

APPENDIX D Continued

TABLE 4

HOSPITAL SERVICES PROVIDED

As Reported to the Blue Cross Commission, December 1, 1946

(Dependents receive the same benefits as the subscriber unless otherwise indicated in the notes.
All plans provide general nursing service and use of the operating room.)

HEADQUARTERS CITY	BOARD & ROOM	SPECIAL DIETS	LABORATORY	DELIVERY ROOM*	EMERGENCY ROOM	ANESTHESIA	DRUGS & MEDICINES	DRESSINGS & CASTS	X-RAY	ELECTRO-CARDIOGRAMS	PHYSIO-THERAPY	OXYGEN THERAPY	BASAL-METABOLISM	PATHOLOGY	OTHER
BOSTON, MASS.	X	X	X	X	X	X	X	X	X (WARD)	X	X (NOTE)	X	X	X	-O-
DETROIT, MICH.	X	X	X	X	X	X	X	X	-O-	-O-	X	X	X	-O-	-O-
ST. PAUL, MINN.	\$5.00 PER DAY	X	X	X	X	X	X	X	TO \$15	X	X	X	X	-O-	SERA, EXTRACTS
KANSAS CITY, MO.	X	X	REG.	X	\$5	SUPPLIES	X	X	-O-	-O-	-O-	X	-O-	-O-	AMBULANCE
ST. LOUIS, MO.	X	X	REG.	X	\$15	-O-	X	X	-O-	-O-	-O-	X	-O-	-O-	AMBULANCE
HELENA, MONT.	\$4.00 PER DAY	X	REG.	X	X	TO \$10	ORD.	X	TO \$15	X	X	TO \$10.	-O-	-O-	PENICILLIN AND STREPTOMYCIN \$10.00
OMAHA, NEBR.	X	-O-	REG.	X (NOTE)	-O-	X	REG.	X	-O-	-O-	-O-	\$15	-O-	-O-	-O-
CONCORD, N. H.	X (NOTE)	X	X	X	-O-	X	X	X	\$25	X	X	X	X	-O-	-O-
NEWARK, N. J.	X	-O-	X	X	\$8	X	REG.	REG.	X	-O-	-O-	-O-	X	-O-	-O-
ALBUQUERQUE, N. M.	X	X	REG.	X	TO \$5	SUPPLIES	ORD.	X	-O-	-O-	-O-	-O-	-O-	-O-	-O-
ALBANY, N. Y.	X	-O-	REG.	X (NOTE)	\$15	X	REG.	REG.	X	X	X	-O-	X	-O-	AMBULANCE
BUFFALO, N. Y.	X	X	X	X	X	SUPPLIES	X	X	-O-	-O-	-O-	X	X	X	AMBULANCE
JAMESTOWN, N. Y.	X	-O-	X	X (NOTE)	X	X	X	X	\$15	X	-O-	-O-	X	-O-	CYSTOSCOPY
NEW YORK, N. Y.	X	X	X	X (NOTE)	TO \$7.25	SUPPLIES	X	X	X	X	X	X	X	-O-	PENICILLIN AND STREPTOMYCIN
ROCHESTER, N. Y.	X	X	X	X (NOTE)	\$10	X	X	X	-O-	X	X	X	X	X	AMBULANCE
SYRACUSE, N. Y.	X	X	X	X (NOTE)	X	-O-	X	X	-O-	-O-	-O-	-O-	-O-	X	AMBULANCE
UTICA, N. Y.	X	X	X	-O- (NOTE)	\$5 SP	-O-	X	X	-O-	-O-	-O-	-O-	-O-	-O-	AMBULANCE
WATERTOWN, N. Y.	X	-O-	REG.	X	-O-	-O-	ORD.	ORD.	-O-	X	X	-O-	X	X	-O-
CHAPEL HILL, N. C.	\$4 OR \$5 PER DAY	X	X	X	X	X	X	X	X	X	X	X	X	X	PENICILLIN \$12.50, INTRAVENOUS SOLUTIONS
DURHAM, N. C.	\$4, \$5 OR \$6 PER DAY	X	X	X	\$7.50	X	X	X	TO \$15	X	X	TO \$25	X	-O-	AMBULANCE \$5, PENICILLIN \$10
FARGO, N. DAK.	X	X	\$8.00	X	X	X	X	X	-O-	-O-	-O-	\$25	\$8.00	-O-	SERA \$8.00
AKRON, OHIO	X	X	50%	X	-O-	MAT'L'S	\$10	X	25%	X	-O-	TO \$25	X	-O-	-O-
CANTON, OHIO	X	X	X	X	X	X	X	X	TO \$15	X	X	X	X	X	ALL OTHER SERVICES
CINCINNATI, OHIO	X	X	X	X	X	MAT'L'S	X	X	X	X	X	X	X	X	-O-
CLEVELAND, OHIO	X	X	REG.	X	-O-	X	ORD.	X	TECH.	X	X	X	X	X	-O-
COLUMBUS, OHIO	X	X	X	X	X	-O-	X	X	-O-	-O-	-O-	X	X (NOTE)	-O-	PENICILLIN
LIMA, OHIO	X	X	X	X	X	-O-	X	X	\$15	-O-	-O-	X	X	X	-O-
PORTSMOUTH, OHIO	X	X	X	X	X	\$10	X	X	TO \$15	-O-	X	X	X	X	SERA, PLASMA, PENICILLIN
TOLEDO, OHIO	X	X	X	X	X (NOTE)	-O-	X	X	-O-	-O-	-O-	-O-	X	X	PENICILLIN
YOUNGSTOWN, OHIO	X	X	X	X	X	X	X	X	-O-	X	X	X	X	X	-O-

*Where (Note) appears in this column, benefits are listed under section entitled "Contract Benefits for Maternity Cases."

[illegible]

NOTES

REG.	PORTLAND, ME.	Ward contract dependent minors pay \$1.00 per day.	Emergency room provided only if a bed patient.
LTD.	BOSTON, MASS.	Physio-therapy not provided on "standard" contract.	When not administered by a salaried employee of the hospital, physio-therapy is limited to \$15.00 and anesthesia to \$10.
ORD.		"Comprehensive" contract provides all services furnished by the hospital and customarily billed to the patient except radium and x-ray therapy, payments to blood donors or blood banks and private nurses.	Provides only ordinary laboratory, drugs and medications, dressings and casts on ward contract. Does not provide electrocardiograms, physio-therapy, oxygen therapy or basal metabolism on ward contract.
BIRMINGHAM, ALA.		Dependents pay \$1.00 per day.	Children pay \$1.00 per day.
WASHINGTON, D. C.		Dependents pay \$1.00 per day.	Allows up to \$4.00 per day on room for dependents.
ALTON, ILL.	KANSAS CITY, MO.	Room and board only on diagnostic admissions.	Electrocardiograms and physio-therapy provided in member hospitals only.
DES MOINES, IA.	OMAHA, NEB.	Semi-private contract dependents pay \$2.00 per day.	Children pay \$1.00 per day.
LOUISVILLE, KY.	CONCORD, N. H.	Ward contract dependents pay \$1.00 per day.	
BATON ROUGE, LA.	UTICA, NEW YORK	Benefits shown are for "comprehensive" contract.	
NEW ORLEANS, LA.	CHAPEL HILL, N. C.	Benefits shown are for "comprehensive" contract.	
	DURHAM, N. C.	Basal metabolism not provided where admission is solely for diagnosis.	
	COLUMBUS, OHIO		

APPENDIX D

TABLE 5

CONTRACT BENEFITS FOR MATERNITY CASES*

(Per Year Unless Otherwise Specified)

As Reported to the Blue Cross Commission, December 1, 1946

HEADQUARTERS CITY	DAYS OF FULL BENEFIT	WAITING PERIOD (MONTHS)	BENEFITS AVAILABLE IN		
			1-PERSON CONTRACT	2-PERSON CONTRACT	FAMILY CONTRACT
BIRMINGHAM, ALA.	7 (NOTE)	12	X	X	X
PHOENIX, ARIZ.	10	9			X
LOS ANGELES, CAL.	\$50 ALLOW.	9		X	X
OAKLAND, CAL.	10 (NOTE)	10		X	X
SACRAMENTO, CAL.	10	10		X	X
DENVER, COLO.	10	9		X	X
NEW HAVEN, CONN.	\$65 ALLOW. (NOTE)	12		X	X
WILMINGTON, DEL.	10 (NOTE)	10		X	X
DIST. OF COLUMBIA	21	10		X	X
JACKSONVILLE, FLA.	10	10		X	X
ATLANTA, GA.	8	12			X
SAVANNAH, GA.	8	12	X	X	X
BOISE, IDAHO	31	10		X	X
ALTON, ILL.	30	10	X	X	X
CHICAGO, ILL.	30 (NOTE)	9		X	X
DANVILLE, ILL.	21	10	X	X	X
DECATUR, ILL.	21	10	X	X	X
PEORIA, ILL.	30 (NOTE)	9			X
ROCKFORD, ILL.	10	12			X
INDIANAPOLIS, IND.	10	10			X
DES MOINES, IA.	10	9		X	X
SIOUX CITY, IA.	10	10			X
TOPEKA, KANS.	10	8			X
ASHLAND, KY.	10	10		X	X
LOUISVILLE, KY.	10	12		X	X
ALEXANDRIA, LA.	7 (NOTE)	10			X
BATON ROUGE, LA.	10	10	X	X	X
NEW ORLEANS, LA.	10	10		X	X
PORTLAND, MAINE	12 (NOTE)	12		X	X
BALTIMORE, MD.	10 (NOTE)	12			X
BOSTON, MASS.	120 (NOTE)	-0-		X	X
DETROIT, MICH.	30 (NOTE)	9	X	X	X
ST. PAUL, MINN.	10	10	X	X	X
KANSAS CITY, MO.	14	10		X	X
ST. LOUIS, MO.	60	10	X	X	X
HELENA, MONT.	10	9			X
OMAHA, NEBR.	30 (NOTE)	12		X	X
CONCORD, N. H.	7	12			X
NEWARK, N. J.	10	9		X	X
ALBUQUERQUE, N. M.	10	10		X	X
ALBANY, N. Y.	10 (NOTE)	10			X
BUFFALO, N. Y.	30	12		X	X
JAMESTOWN, N. Y.	21 (NOTE)	11		X	X
NEW YORK, N. Y.	10 (NOTE)	10			X
ROCHESTER, N. Y.	10 (NOTE)	10			X
SYRACUSE, N. Y.	14 (NOTE)	11			X
UTICA, N. Y.	10 (NOTE)	10		X	X
WATERTOWN, N. Y.	10	11			X
CHAPEL HILL, N. C.	30 (NOTE)	10			X
DURHAM, N. C.	10 (NOTE)	10		X	X

*Benefits here listed refer to "normal" delivery of maternity cases. Many plans provide the same benefits as for medical and surgical cases where surgery or "complications" are involved.

APPENDIX D- 5 (Continued)

HEADQUARTERS CITY	DAYS OF FULL BENEFIT	WAITING PERIOD (MONTHS)	BENEFITS AVAILABLE IN		
			1-PERSON CONTRACT	FAMILY CONTRACT	2-PERSON CONTRACT
FARGO, N. DAK.	10 (NOTE)	10	1	1	X
AKRON, OHIO	10	9		X	X
CANTON, OHIO	30	12			X
CINCINNATI, OHIO	10	9		X	X
CLEVELAND, OHIO	30 (NOTE)	12	X	X	X
COLUMBUS, OHIO	10	10		X	X
LIMA, OHIO	31	10		X	X
PORTSMOUTH, OHIO	21 (NOTE)	9	X	X	X
TOLEDO, OHIO	21 (NOTE)	12			X
YOUNGSTOWN, OHIO	21 (NOTE)	10	X	X	X
TULSA, OKLA.	10	10	X	X	X
PORTLAND, ORE.	10	10		X	X
ALLEN TOWN, PA.	10	12			X
HARRISBURG, PA.	21 (NOTE)	9		X	X
PHILADELPHIA, PA.	10	12			X
PITTSBURGH, PA.	10	12			X
WILKES-BARRE, PA.	21 (NOTE)	12		X	X
PROVIDENCE, R. I.	\$65	(NOTE)		X	X
CHATTANOOGA, TENN.	10	10		X	X
KINGSFORT, TENN.	21 (NOTE)	10		X	X
DALLAS, TEXAS	10	12			X
SALT LAKE CITY, U.	21	10			X
LYNCHBURG, VA.	10	12		X	X
NEWPORT NEWS, VA.	10	10	X	X	X
NORFOLK, VA.	10	10	X	X	X
RICHMOND, VA.	10	10		X	X
ROANOKE, VA.	10	9			X
SEATTLE, WASH.	10 (NOTE)	10			X
CHARLESTON, W. VA.	\$25	10	X	X	X
HUNTINGTON, W. VA.	\$40	10		X	X
MILWAUKEE, WIS.	(NOTE)	9		X	X
SAN JUAN, P. R.	21 (NOTE)	12			X
VANCOUVER, B. C.	10	12			X
WINNIPEG, MAN.	10	12	X	X	X
MONCTON, NEW BRUN.	(NOTE)	10			X
TORONTO, ONTARIO	(NOTE)	12			X
MONTREAL, QUEBEC	(NOTE)	10		X	X

NOTES

BIRMINGHAM, ALA.	14 days for Caesarian.
OAKLAND, CAL.	Allows \$5.00 per day.
NEW HAVEN, CONN.	Allowance of \$65.00 for childbirth, normal or otherwise is counted as 8 days care.
WILMINGTON, DEL.	Ward allowance \$4.00 per day; semi-private allowance \$5.50 per day.
CHICAGO, ILL.	Additional 90 days at 50% discount.
PEORIA, ILL.	Additional 90 days at 50% discount.
ALEXANDRIA, LA.	10 days for Caesarian.
PORTLAND, ME.	21 days Caesarian.
BALTIMORE, MD.	Allows \$5.00 per day.

APPENDIX D- 5 (Continued)

NOTES

BOSTON, MASS.	Benefits shown are for "comprehensive" contract and are provided for each admission. "Standard" contract provides 30 days at 50% discount plus an additional 90 days at 25% discount per admission; the waiting period is six months and benefits are provided on two-person and family contracts.
DETROIT, MICH.	Additional 90 days at 50% discount.
OMAHA, NEB.	Additional 120 days at 50% discount. Subscriber pays \$1.00 per day for maternity care.
ALBANY, N. Y.	Allows \$6.00 per day.
JAMESTOWN, N. Y.	Allows \$4.00 per day.
NEW YORK, N. Y.	Ward allowance \$4.00 per day; semi-private allowance \$6.00 per day. Allows 21 full days plus 180 days at 50% discount for caesarian, miscarriage and abortion.
ROCHESTER, N. Y.	Allows \$6.00 per day.
SYRACUSE, N. Y.	Allows \$3.50 per day.
UTICA, N. Y.	Allows \$4.00 per day.
CHAPEL HILL, N. C.	Benefits are for "comprehensive" contract.
DURHAM, N. C.	Benefits are for "comprehensive" contract.
FARGO, N. D.	Additional 10 days at 50% discount.
CLEVELAND, O.	Additional 90 days at 50% discount.
PORTSMOUTH, O.	31 days second year and thereafter. Additional 90 days provided at 50% discount.
TOLEDO, O.	31 days second year and thereafter.
YOUNGSTOWN, O.	21 days second year, 31 days third year.
HARRISBURG, PA.	25 days second year, 30 days third year and thereafter. Additional 90 days at 50% discount.
WILKES-BARRE, PA.	25 days second year, 30 days third year and thereafter. Additional 90 days at 50% discount.
PROVIDENCE, R. I.	7 month waiting period for "standard" and "direct payment" contract.
KINGSPORT, TENN.	24 days second year, 24 days third year, 27 days fourth year, 30 days fifth year and thereafter.
SEATTLE, WASH.	Allows \$8.50 per day.
MILWAUKEE, WIS.	10 days at 50% discount.
SAN JUAN, P. R.	Additional 69 days at 25% discount.
MONCTON, N. B.	12 days at 50% discount. Includes Prince Edward Island, Nova Scotia and New Brunswick.
TORONTO, ONTARIO	12 days at 50% discount.
MONTREAL, QUEBEC	21 days first year, 31 days second year and thereafter; all benefits at 50% discount.

APPENDIX D

TABLE 6

CONTRACT BENEFITS FOR NERVOUS AND MENTAL, TUBERCULOSIS AND QUARANTINABLE CASES
(PER YEAR UNLESS OTHERWISE SPECIFIED)

(As reported to the Blue Cross Commission, December 1, 1946)

HEADQUARTERS CITY	DAYS OF SERVICE					
	NERVOUS & MENTAL		TUBERCULOSIS		QUARANTINABLE	
	BENEFITS 1ST YR.	ADD'L DAYS DISCOUNT	BENEFITS 1ST YR.	ADD'L DAYS DISCOUNT	BENEFITS 1ST YR.	ADD'L DAYS DISCOUNT
BIRMINGHAM, ALA.	-0-	-0-	-0-	-0-	-0-	-0-
PHOENIX, ARIZ.	21	-0-	21	90 - 50%	21	90 - 50%
LOS ANGELES, CAL.	21	180 - 50%	21	180 - 50%	21	180 - 50%
OAKLAND, CAL.	-0-	-0-	21	-0-	21	180 - 50%
SACRAMENTO, CAL.	-0-	-0-	-0-	-0-	21	-0-
DENVER, COLO.	30	-0-	30	-0-	30	90 - 50%
NEW HAVEN, CONN.	21	-0-	21	-0-	21	90 - \$3.00
WILMINGTON, DEL.	30	30 - \$2.50	-0-	-0-	30	-0-
DIST. OF COLUMBIA	-0-	-0-	UD	-0-	-0-	-0-
JACKSONVILLE, FLA.	7	-0-	7	-0-	31	90 - 25%
ATLANTA, GA.	-0-	-0-	-0-	-0-	-0-	-0-
SAVANNAH, GA.	21	30 - \$2.50	-0-	-0-	21	-0-
BOISE, IDAHO	31	-0-	31	-0-	31	-0-
ALTON, ILL.	14	-0-	14	-0-	30	-0-
CHICAGO, ILL.	30	90 - 50%	30	90 - 50%	30	90 - 50%
DANVILLE, ILL.	-0-	-0-	-0-	-0-	21	-0-
DECATUR, ILL.	-0-	-0-	-0-	-0-	-0-	-0-
PEORIA, ILL.	30	90 - 50%	30	90 - 50%	30	90 - 50%
ROCKFORD, ILL.	-0-	-0-	21	-0-	21	-0-
INDIANAPOLIS, IND.	30	30 - 50%	14	-0-	21	-0-
DES MOINES, IA.	21	-0-	21	-0-	21	90 - 50%
SIOUX CITY, IA.	UD	-0-	UD	-0-	UD	-0-
TOPEKA, KANS.	90	-0-	90	-0-	90	-0-
ASHLAND, KY.	-0-	-0-	10	-0-	-0-	-0-
LOUISVILLE, KY.	UD	-0-	UD	-0-	UD	-0-
ALEXANDRIA, LA.	UD	UD	UD	-0-	30	90 - 50%
BATON ROUGE, LA.	-0-	-0-	-0-	-0-	30	-0-
NEW ORLEANS, LA.	-0-	-0-	-0-	-0-	-0-	-0-
PORTLAND, ME.	UD	-0-	UD	-0-	UD	-0-
BALTIMORE, MD.	-0-	-0-	-0-	-0-	-0-	-0-
BOSTON, MASS.	30	-0-	30	-0-	120	-0-
DETROIT, MICH.	30	90 - 50%	30	90 - 50%	30	90 - 50%
ST. PAUL, MINN.	30	-0-	30	-0-	120	-0-
KANSAS CITY, MO.	14	-0-	14	-0-	14	-0-
ST. LOUIS, MO.	14	-0-	14	-0-	60	-0-
HELENA, MONT.	-0-	-0-	-0-	-0-	-0-	-0-
OMAHA, NEBR.	10	-0-	10	-0-	10	-0-
CONCORD, N. H.	30	90 - 50%	30	90 - 50%	30	90 - 50%
NEWARK, N. J.	21	90 to \$3.63	21	90 to \$3.63	21	90 to \$3.63
ALBUQUERQUE, N. M.	UD	-0-	UD	UD	30	90 - 50%
ALBANY, N. Y.	-0-	-0-	-0-	-0-	21	-0-
BUFFALO, N. Y.	-0-	-0-	-0-	-0-	-0-	-0-
JAMESTOWN, N. Y.	-0-	-0-	-0-	-0-	-0-	-0-
NEW YORK, N. Y.	NOTE	-0-	NOTE	-0-	NOTE	-0-
ROCHESTER, N. Y.	-0-	-0-	-0-	-0-	-0-	-0-
SYRACUSE, N. Y.	-0-	-0-	-0-	-0-	21	60 - 50%
UTICA, N. Y.	-0-	-0-	-0-	-0-	21	-0-
WATERTOWN, N. Y.	-0-	-0-	-0-	-0-	-0-	-0-
CHAPEL HILL, N. C.	30	-0-	UD	-0-	30	-0-
DURHAM, N. C.	31	-0-	31	-0-	60	-0-

APPENDIX D- 6 (Continued)

HEADQUARTERS CITY	DAYS OF SERVICE					
	NERVOUS & MENTAL		TUBERCULOSIS		QUARANTINABLE	
	BENEFITS 1ST YR.	ADD'L DAYS DISCOUNT	BENEFITS 1ST YR.	ADD'L DAYS DISCOUNT	BENEFITS 1ST YR.	ADD'L DAYS DISCOUNT
FARGO, N. D.	UD	-0-	UD	-0-	21	-0-
AKRON, OHIO	30	90 - 50%	30	90 - 50%	30	90 - 50%
CANTON, OHIO	30	90 - \$3.00	-0-	-0-	30	90 - \$3.00
CINCINNATI, OHIO	21	-0-	21	-0-	21	-0-
CLEVELAND, OHIO	30	90 - 50%	-0-	-0-	30	90 - 50%
COLUMBUS, OHIO	-0-	-0-	-0-	-0-	-0-	-0-
LIMA, OHIO	-0-	-0-	-0-	-0-	-0-	-0-
PORTSMOUTH, OHIO	21	90 - 50%	21	90 - 50%	21	90 - 50%
TOLEDO, OHIO	-0-	-0-	31	-0-	21	-0-
YOUNGSTOWN, OHIO	-0-	-0-	UD	-0-	-0-	-0-
TULSA, OKLA.	-0-	-0-	-0-	-0-	-0-	-0-
PORTLAND, ORE.	-0-	-0-	-0-	-0-	-0-	-0-
ALLENTOWN, PA.	21	-0-	10	-0-	21	-0-
HARRISBURG, PA.	21	90 - 50%	21	90 - 50%	21	90 - 50%
PHILADELPHIA, PA.	10	-0-	10	-0-	21 NOTE	-0-
PITTSBURGH, PA.	-0-	-0-	-0-	-0-	21	90 - 50%
WILKES-BARRE, PA.	21	-0-	21	-0-	21	-0-
PROVIDENCE, R. I.	45	-0-	45	-0-	75	-0-
CHATTANOOGA, TENN.	UD	-0-	UD	-0-	21	-0-
KINGSPORT, TENN.	-0-	-0-	21	-0-	-0-	-0-
DALLAS, TEXAS	30	90 - 50%	30	-0-	30	-0-
SALT LAKE CITY, U.	10	-0-	10	-0-	21 NOTE	-0-
LYNCHBURG, VA.	-0-	-0-	-0-	-0-	21	21 - 50%
NEWPORT NEWS, VA.	25	-0-	-0-	-0-	25	-0-
NORFOLK, VA.	7	-0-	7	-0-	-0-	-0-
RICHMOND, VA.	30	-0-	30	-0-	30	120 - 50%
ROANOKE, VA.	21	NOTE	21	NOTE	21	NOTE
SEATTLE, WASH.	-0-	-0-	-0-	-0-	-0-	-0-
CHARLESTON, W. VA.	-0-	-0-	UD	-0-	-0-	-0-
HUNTINGTON, W. VA.	-0-	-0-	UD	-0-	60	-0-
MILWAUKEE, WIS.	60	-0-	60	-0-	42	-0-
SAN JUAN, P. R.	UD	-0-	UD	-0-	-0-	-0-
VANCOUVER, B. C.	-0-	-0-	-0-	-0-	30	-0-
WINNIPEG, MANITOBA	-0-	-0-	-0-	-0-	-0-	-0-
MONCTON, NEW BRUN.	30	-0-	30	-0-	30	-0-
TORONTO, ONTARIO	31	-0-	30	-0-	31	-0-
MONTREAL, QUEBEC	-0-	-0-	-0-	-0-	-0-	-0-

NOTES

UD

Until Diagnosed.

PHOENIX, ARIZONA

Nervous and mental: 25 days second year, 30 days third year and thereafter. Tuberculosis: 25 days second year, 30 days third year, and thereafter, member hospitals only. Quarantinable: 25 days second year, 30 days third year and thereafter. Allows \$3.00 day on communicable.

OAKLAND, CAL.

Tuberculosis: Until diagnosed up to 21 days.

SACRAMENTO, CAL.

Quarantinable: Allows 7 days more each year to a maximum of 49 days sixth year and thereafter.

NEW HAVEN, CONN.

Nervous and Mental, Tuberculosis: In general hospitals only. Quarantinable: No coverage for children under age 19 except in cases where the Plan is satisfied that care is strictly necessary.

JACKSONVILLE, FLA.

Nervous and Mental, Tuberculosis: 31 days in sanitarium.

APPENDIX D - 6 (Continued)

NOTES

SAVANNAH, GA.	Nervous and Mental, Quarantinable: 25 days second year 30 days third year and thereafter.
ALTON, ILL.	Tuberculosis: Or up to \$90.00 in private or governmental sanitarium.
ROCKFORD, ILL.	Tuberculosis, Quarantinable: 24 days second year, 27 days third year, 30 days fourth year, and thereafter.
DES MOINES, IA.	25 days second year, 30 days third year and thereafter; applies to all types of illness here listed.
LOUISVILLE, KY.	Nervous and Mental, Tuberculosis: For initial period only. Coverage for all three classes provided only in member hospitals.
PORTLAND, ME.	All classes: Contractually no benefit after diagnosis: "conditional" service dividend allows up to 21 days general hospital care after 6 months membership.
BOSTON, MASS.	All classes: Benefits shown are per admission on "comprehensive" contract.
ST. PAUL, MINN.	Quarantinable: Allows \$3.00 per day for 120 days.
ST. LOUIS, MO.	Tuberculosis: Or up to \$90.00 in private or governmental sanitarium.
ALBANY, N.Y.	Quarantinable: 42 days second year, 60 days thereafter.
NEW YORK, N.Y.	All classes: contractually, no benefits; in practice, limited benefits; nervous and mental - shock therapy; tuberculosis - surgical procedures only; quarantinable - adult subscribers only.
SYRACUSE, N.Y.	Quarantinable: 42 days second year, 60 days thereafter.
UTICA, N.Y.	Quarantinable: 25 days per year thereafter.
CHAPEL HILL, N.C.	Benefits shown are for "comprehensive" coverage.
DURHAM, N.C.	Tuberculosis: in general hospitals. Benefits shown are provided on "comprehensive" contract.
FARGO, N.D.	Quarantinable: If no care used previous year. Subscriber receives 7 additional days each year up to total of 35 days in third year.
CINCINNATI, OHIO	All classes: 30 days second year and thereafter.
PORTSMOUTH, OHIO	All classes: 31 days second year and thereafter.
TOLEDO, OHIO	Tuberculosis: 31 days for life of contract after new contract has been in effect 12 months. Quarantinable: 31 days second year and thereafter.
ALLENTOWN, PA.	Nervous and mental, quarantinable: 24 days second year, 27 days third year, 30 days fourth year and thereafter. Tuberculosis: surgical only.
HARRISBURG, PA.	All classes: 25 days second year, 30 days third year and thereafter.
PHILADELPHIA, PA.	In non-member, contagious disease hospital: \$4.00 per day for 21 days.
WILKES-BARRE, PA.	All classes: 25 days second year, 30 days third year and thereafter.
PROVIDENCE, R.I.	Benefits shown are for "comprehensive" contract. "Standard" and "direct" payment contracts provide 31 full days for each of the three types of cases and no discount period.
KINGSPORT, TENN.	Tuberculosis: 24 days second year, 27 days third year, 30 days fourth year and thereafter - for diagnosis and special surgical procedures.
SALT LAKE CITY, UTAH	Nervous and mental, tuberculosis: until diagnosed up to 10 days. Quarantinable only if admitted to a member hospital.

APPENDIX D- 6 (Continued)

NOTES

RICHMOND, VA.	All classes: 35 days after first year. Discount period for "quarantinable" applies after first year and in member hospitals only.
ROANOKE, VA.	All classes: 23 days second year, 26 days third year, 30 days fourth year, 35 days fifth year and thereafter. Discount days at \$3.50 per diem are the same as allowed for full benefits.
MILWAUKEE, WIS.	All classes: allows up to \$3.00 per day.
TORONTO, ONTARIO	All classes: 36 days second year, 41 days third year, 46 days fourth year, 51 days fifth year and thereafter.
MONCTON, NEW BRUN.	Includes: Prince Edward Island, Nova Scotia and New Brunswick.

APPENDIX D

TABLE 7

ALLOWANCES TOWARDS "BETTER" ACCOMMODATIONS December 1, 1946

Data from the Blue Cross Commission

HEADQUARTERS CITY AND STATE	ALLOWANCE TOWARD BETTER ACCOMMODATIONS		SPECIAL SERVICES PROVIDED IN BETTER ACCOMMODATIONS
	SEMI-PRIVATE CONTRACT HOLDERS	WARD-CONTRACT HOLDERS	
BIRMINGHAM, ALA. PHOENIX, ARIZ. LOS ANGELES, CALIF. OAKLAND, CALIF. SACRAMENTO, CALIF.	\$5.00 (P) CH. \$5.00	\$3.00 CH. CH.	A A A A A
DENVER, COLO. NEW HAVEN, CONN. WILMINGTON, DEL. WASHINGTON, D. C. JACKSONVILLE, FLA.	\$4.00 CH. \$4.00 CH.	\$4.00 \$5.00	A A A A A
ATLANTA, GA. SAVANNAH, GA. BOISE, IDAHO ALTON, ILL. CHICAGO, ILL.	MIN. (P) MIN. (P) \$4.50 \$5.00	CH. CH. (S-P) CH.	A A A A A
DANVILLE, ILL. DECATUR, ILL. PEORIA, ILL. ROCKFORD, ILL. INDIANAPOLIS, IND.	\$3.50 \$3.50 \$5.00 \$3.50 \$4.50	\$3.25	A A A A A
DES MOINES, IA. SIOUX CITY, IA. TOPEKA, KAN. ASHLAND, KY. LOUISVILLE, KY.	\$4.75 \$4.75 \$4.00 CH. \$5.00		A A A A A
ALEXANDRIA, LA. BATON ROUGE, LA. NEW ORLEANS, LA. PORTLAND, ME. BALTIMORE, MD.	\$5.00* \$6.00 (P) \$5.50* (P) CH. \$5.00	\$4.00 \$3.50* (S-P) CH.	A A A A A
BOSTON, MASS. DETROIT, MICH. ST. PAUL, MINN. KANSAS CITY, MO. ST. LOUIS, MO.	CH. CH. \$5.00* \$4.50 \$4.50	\$4.50* CH.	A A A A A
HELENA, MONT. OMAHA, NEB. CONCORD, N.H. NEWARK, N. J. ALBUQUERQUE, N. M.	\$4.00 \$4.00 CH. * \$3.50		A A A A A
ALBANY, N. Y. BUFFALO, N. Y. JAMESTOWN, N. Y. NEW YORK, N. Y. ROCHESTER, N. Y.	\$4.00 \$4.50 \$4.00 * \$6.00	\$3.50 *	A A A A A
SYRACUSE, N. Y. UTICA, N. Y. WATERTOWN, N. Y. CHAPEL HILL, N. C. DURHAM, N. C.	CH. \$4.50 CH. \$5.00 \$6.00 (P)	\$3.50 \$4.00 \$5.00* (S-P)	A* A A A A

APPENDIX D - 7 (Continued)

HEADQUARTERS CITY AND STATE	ALLOWANCE TOWARD BETTER ACCOMMODATIONS		SPECIAL SERVICES PROVIDED IN BETTER ACCOMMODATIONS
	SEMI-PRIVATE CONTRACT HOLDERS	WARD-CONTRACT HOLDERS	
FARGO, N. D. AKRON, OHIO CANTON, OHIO CINCINNATI, OHIO CLEVELAND, OHIO	\$3.50 CH. CH. \$4.50 \$7.00	CH. CH. \$3.25 \$6.00	A A A A *
COLUMBUS, OHIO LIMA, OHIO PORTSMOUTH, OHIO TOLEDO, OHIO YOUNGSTOWN, OHIO	CH. CH. CH. (P) CH. CH.	CH. CH. CH. CH.	A A A A A
TULSA, OKLA. PORTLAND, ORE. ALLENTOWN, PA. HARRISBURG, PA. PHILADELPHIA, PA.	\$4.50 \$4.00 CH. \$5.00	\$3.50 CH. \$3.75	A A A *
PITTSBURGH, PA. WILKES-BARRE, PA. PROVIDENCE, R. I. CHATTANOOGA, TENN. KINGSPORT, TENN.	\$5.00 CH. \$6.00 \$4.50	\$3.50 CH. CH.	* A * A *
DALLAS, TEXAS SALT LAKE CITY, UTAH LYNCHBURG, VA. NEWPORT NEWS, VA. NORFOLK, VA.	\$5.00 CH. \$4.50 \$4.50 \$5.00 (P)	\$3.50 \$3.00	A A A A
RICHMOND, VA. ROANOKE, VA. SEATTLE, WASH. CHARLESTON, W. VA. HUNTINGTON, W. VA.	\$5.00 \$4.50 \$5.00 \$3.50	\$3.00 CH.	A A A A A
MILWAUKEE, WIS. SAN JUAN, P. R. VANCOUVER, B. C. WINNIPEG, MAN. MONCTON, N. B.	MAX. NO INFORMATION \$3.50 CH.	CH. CH.	A A A
TORONTO, ONT. MONTREAL, QUE.	CH. *	CH.	A *

CODE

- A Full coverage on "special" services in subscribers contract. There is no extra charge to the patient except the difference in room rates.
- CH. Regular rate for the type of room covered in the subscribers contract.
- Max. Maximum rate.
- Min. Minimum rate for the type of room covered in the subscribers contract.
- N.D. Not defined.
- (P) Private.
- (S-P) Semi-Private.

*See notes below

NOTES

ROCKFORD, ILL. \$20.00 or \$35.00 per case toward special services depending on contract selected.

APPENDIX D - 7 (Continued)

NOTES

ALEXANDRIA, LA.	Dependents allowed \$4.00 per day.
NEW ORLEANS, LA.	Dependents allowed \$3.00 and \$2.50 per day.
PORTLAND, ME.	Not to exceed \$25.00 (combined) for any admission.
BALTIMORE, MD.	50% discount on contract special services.
BOSTON, MASS.	Ward contracts provide \$4.50 per day toward total bill.
ST. PAUL, MINN.	Allowance shown is for "Plan A comprehensive group contract subscribers." "Plan B" allows up to \$3.00 per day. Modified full coverage contract allows up to \$4.00 per day.
NEWARK, N. J.	Credit up to amount of payment schedule toward total bill.
NEW YORK, N. Y.	Credit equal to plan payment to hospital for contract benefits.
SYRACUSE, N. Y.	Credit equal to plan payment to hospital for contract benefits.
UTICA, N. Y.	Code A for S-P; W included in room allowance.
DURHAM, N. C.	Ward - \$4.00 per day.
CLEVELAND, O.	Included in room allowance.
PHILADELPHIA, PA.	Credits at S-P rates on "Special" services for S-P contract subscriber.
PITTSBURGH, PA.	Code A for S-P; W subscriber pays difference in cost for special service.
WILKES-BARRE, PA.	Subscriber pays difference between contract benefits provided and charges for accommodation selected.
KINGSPORT, TENN.	Subscriber pays difference between contracts provided and charges for accommodations selected.
DALLAS, TEX.	Dependents \$4.00 per day.
MONTREAL, QUEBEC	\$5.50 per day on total bill or \$4.00 per day on room, plus \$20.00 toward special services, whichever is greater.

APPENDIX D

TABLE 8

NON-MEMBER HOSPITAL ALLOWANCES

As Reported to the Blue Cross Commission, December 1, 1946

HEADQUARTERS CITY	PER DIEM ALLOWANCES			
	SEMI-PRIVATE		WARD	
	SUBSCRIBER	DEPENDENT	SUBSCRIBER	DEPENDENT
BIRMINGHAM, ALA.	6.50P	6.50P	4.50	4.50
PHOENIX, ARIZ.	6.00	6.00	-0-	-0-
LOS ANGELES, CAL.	-0-		REGULAR CHARGES	
OAKLAND, CAL.	-0-		REGULAR CHARGES	
SACRAMENTO, CAL.		REGULAR CHARGES		
DENVER, COLO.	6.00	6.00	-0-	-0-
NEW HAVEN, CONN.	-NOTE-		4.00	4.00
WILMINGTON, DEL.	5.50	5.50	-0-	-0-
DIST. OF COLUMBIA	6.50	6.50	6.00	6.00
JACKSONVILLE, FLA.	-0-	-0-		
ATLANTA, GA.	6.00P	6.00P	4.00	4.00
SAVANNAH, GA.	6.00P	6.00P	4.00SP	4.00SP
BOISE, IDAHO	-0-	-0-	5.00	5.00
ALTON, ILL.	5.00	4.00	-0-	-0-
CHICAGO, ILL.	6.00	6.00	-0-	-0-
DANVILLE, ILL.	5.00	5.00	-0-	-0-
DECATUR, ILL.	6.00	6.00	-0-	-0-
PEORIA, ILL.	6.00	6.00	-0-	-0-
ROCKFORD, ILL.	5.00	5.00	-0-	-0-
INDIANAPOLIS, IND.		FULL CONTRACT BENEFITS		
DES MOINES, IA.	\$6.00 (NOTE)	\$6.00	-0-	-0-
SIOUX CITY, IA.	5.50	5.50	-0-	-0-
TOPEKA, KANS.	-NOTE-		-0-	-0-
ASHLAND, KY.	6.00	6.00	-0-	-0-
LOUISVILLE, KY.	6.00P	6.00P	5.00	5.00
ALEXANDRIA, LA.	7.00	7.00	-0-	-0-
BATON ROUGE, LA.	6.50P	6.50P	4.00	3.00
NEW ORLEANS, LA.	TO SCHEDULE PAID PARTICIPATING HOSPITALS		4.00	3.00
PORTLAND, MAINE	6.00	6.00	-0-	-0-
BALTIMORE, MD.	6.00	6.00		
BOSTON, MASS.	-NOTE-		4.50	4.50
DETROIT, MICH.	6.50	6.50	5.00	5.00
ST. PAUL, MINN.	6.00	6.00	-0-	-0-
KANSAS CITY, MO.	6.00	5.00	-0-	-0-
ST. LOUIS, MO.	6.00	4.00	-0-	-0-
HELENA, MONT.	5.00	5.00	-0-	-0-
OMAHA, NEBR.	5.00 -NOTE-	4.00	-0-	-0-
CONCORD, N. H.	5.00	5.00	-0-	-0-
NEWARK, N. J.	-NOTE-		-0-	-0-
ALBUQUERQUE, N. M.	5.00	5.00	-0-	-0-
ALBANY, N. Y.	UP TO \$6.00		-0-	-0-
BUFFALO, N. Y.	6.00	5.00	4.50	4.50
JAMESTOWN, N. Y.	6.50	6.50	-0-	-0-
NEW YORK, N. Y.	-NOTE-		-0-	-0-
ROCHESTER, N. Y.	6.50	6.50		
SYRACUSE, N. Y.	UP TO 6.00		-0-	-0-
UTICA, N. Y.	5.50	3.50	4.50	3.50
WATERTOWN, N. Y.	6.00	6.00	-0-	-0-
CHAPEL HILL, N. C.	-NOTE-		-0-	-0-
DURHAM, N. C.	-NOTE-			

APPENDIX D- 8 (Continued)

HEADQUARTERS CITY	PER DIEM ALLOWANCES			
	SEMI-PRIVATE		WARD	
	SUBSCRIBER	DEPENDENT	SUBSCRIBER	DEPENDENT
FARGO, N. DAK.	5.00	5.00	-0-	-0-
AKRON, OHIO	6.00	6.00	5.00	5.00
CANTON, OHIO	7.00	7.00	6.00	6.00
CINCINNATI, OHIO	6.75	6.75	5.25	5.25
CLEVELAND, OHIO	6.00	6.00	4.50	4.50
COLUMBUS, OHIO	6.00	6.00	5.00	5.00
LIMA, OHIO	6.00	6.00	-0-	-0-
PORTSMOUTH, OHIO	6.00	6.00	4.50	4.50
TOLEDO, OHIO	6.00	6.00	4.50	4.50
YOUNGSTOWN, OHIO		SAME AS TO PARTICIPATING HOSPITAL		
TULSA, OKLA.	5.00	5.00	4.00	4.00
PORTLAND, ORE.	-0-	-0-	5.50	5.50
ALLENTOWN, PA.	6.00	6.00	-0-	-0-
HARRISBURG, PA.	6.00	6.00	-0-	-0-
PHILADELPHIA, PA.	5.50	5.50	3.75	3.75
PITTSBURGH, PA.	6.50	6.50	5.00	5.00
WILKES-BARRE, PA.	6.00	6.00	4.25	4.25
PROVIDENCE, R. I.	6.00	6.00	6.00	6.00
CHATTANOOGA, TENN.	6.00	6.00	-0-	-0-
KINGSFORT, TENN.	-0-	-0-	5.00	4.00
DALLAS, TEXAS	6.00	5.00	-0-	-0-
SALT LAKE CITY, U.	5.00	5.00	-0-	-0-
LYNCHBURG, VA.	5.50	5.50	4.50	4.50
NEWPORT NEWS, VA.	5.00	5.00	-0-	-0-
NORFOLK, VA.	6.00	6.00	4.00	4.00
RICHMOND, VA.	6.25	6.25	-0-	-0-
ROANOKE, VA.	6.25	6.25	4.75	4.75
SEATTLE, WASHINGTON		NONE EXCEPT UNDER RECIPROCITY		
CHARLESTON, W. VA.		\$10.00 FIRST DAY, \$5.00 THEREAFTER		
HUNTINGTON, W. VA.	5.00	5.00	-0-	-0-
MILWAUKEE WIS.	5.00	4.00	-0-	-0-
SAN JUAN, P. R.	4.00	4.00	-0-	-0-
VANCOUVER, BRIT, COL.	-0-	-0-	REGULAR CHARGES	
WINNIPEG, MANITOBA	5.00	4.00	-0-	-0-
MONCTON, NEW BRUN.	5.25	5.25	3.25	3.25
TORONTO, ONTARIO		REGULAR CHARGES FOR BENEFITS AS LISTED		
MONTREAL, QUEBEC	5.50	5.50	-0-	-0-

NOTES

P PRIVATE SP SEMI-PRIVATE

BIRMINGHAM, ALA.

Maternity allowance - Ward \$5.00: Private \$7.00 for subscribers and dependents.

DENVER, COLO.

30 days at \$6.00 plus 90 days at \$3.00. Quarantinable cases: 30 days at \$3.00 plus 90 days at \$1.50.

NEW HAVEN, CONN.

1 day \$15.00; 2 days \$20.00; 3 days \$25.00; 4 to 21 days \$7.50 per day; 90 additional days at \$3.00 per day. \$65.00 maternity: by credit \$7.50 emergency accident room.

WILMINGTON, DEL.

Plus an additional allowance of \$7.50 per case for auxiliary services to semi-private plan members, and \$4.50 per case for ward members. Maternity care, Semi-private \$5.50; ward \$4.00 per day for 10 days.

WASHINGTON, D.C.

Allows \$1.00 per day for nursery care.

DES MOINES, IA.

"Combination" contract: \$5.40 per day for subscriber or dependents.

TOPEKA, KANS.

1 day \$11.00; 2 days \$16.50; 3 days \$20.00. Pays up to \$5.35 per day.

APPENDIX D- 8 (Continued)

NOTES

PORTLAND, ME.	1 day \$12.00; 2 days \$16.00; 3 days \$20.00.																																																
BOSTON, MASS.	Benefits shown are for "standard" contract; Plan pays up to highest rate paid to a member hospital for service benefits. "Comprehensive" contract also provides up to highest rate paid to a member hospital for service benefits, except for tuberculosis, nervous and mental conditions, not more than 30 days per admission, and not over \$5.00 per day.																																																
DETROIT, MICHIGAN	In member hospitals of other plans - ward service \$5.00; semi-private \$6.50.																																																
ST. PAUL, MINN.	Rate applies to first 30 days, additional 90 days at \$3.00 per day.																																																
KANSAS CITY, MO.	Rates apply to non-member hospitals away from area of member hospitals.																																																
OMAHA, NEB.	30 days, coverage. No additional discount period.																																																
CONCORD, N.H.	Rate shown is for room and board, extras provided as in member hospital.																																																
NEWARK, N.J.	1 day, \$18.00; 2 days, \$22.00; 3 days, \$31.00; 5 days, \$49.00; graded up to \$77.00 for 9 days; thereafter \$6.00 per day additional through 21 days. Additional 90 days up to \$3.63 per day. Pays \$1.00 per day (during joint confinement of mother and infant) for newborn child during maximum payment period and up to \$.50 per day during partial payment period calculated from date of birth.																																																
ALBANY, N.Y.	Special short stay rates.																																																
BUFFALO, N.Y.	Special short stay rates.																																																
JAMESTOWN, N.Y.	1 day, \$15.00; 2 days, \$20.00; 3 days, \$23.00; 4 days or more, \$6.50 per day.																																																
NEW YORK, N.Y.	Credit of amount of member hospital payment schedule. e.g., ward contract, \$30.00 for 5 day stay or \$50.00 for 10 day stay; semi-private contract \$50.00 for 5 day stay or \$85.00 for 10 day stay.																																																
ROCHESTER, N.Y.	1 day, \$13.00.																																																
UTICA, N.Y.	Maternity allowance \$4.00 per day semi-private, \$3.50 per day ward.																																																
WATERTOWN, N.Y.	Maternity allowance \$4.00 per day.																																																
CHAPEL HILL, N.C.	Indemnity allowances:																																																
	<table><tr><td></td><td>Comprehensive</td><td>Reg. Ward</td></tr><tr><td>Room</td><td>\$4.00 or \$5.00</td><td>\$ 3.00</td></tr><tr><td>Oper. Room (Major)</td><td>10.00</td><td>10.00</td></tr><tr><td>Oper. Room (Minor)</td><td>5.00</td><td>5.00</td></tr><tr><td>Delivery room</td><td>10.00</td><td>10.00</td></tr><tr><td>Out-Pat. accident (24 hrs.)</td><td>10.00</td><td>7.50</td></tr><tr><td>Anesthesia (Major \$7.50), minor</td><td>5.00</td><td>5.00</td></tr><tr><td>Laboratory</td><td>5.00</td><td>3.00</td></tr><tr><td>X-ray exam.</td><td>10.00</td><td>10.00</td></tr><tr><td>Basal-metabolism</td><td>5.00</td><td>-0-</td></tr><tr><td>Electro-cardiograms</td><td>10.00</td><td>-0-</td></tr><tr><td>Physio-therapy</td><td>10.00</td><td>-0-</td></tr><tr><td>Oxygen therapy</td><td>25.00</td><td>20.00</td></tr><tr><td>Casts (Material)</td><td>10.00</td><td>5.00</td></tr><tr><td>Pathology</td><td>5.00</td><td>-0-</td></tr><tr><td>Penicillin</td><td>10.00</td><td>-0-</td></tr></table>		Comprehensive	Reg. Ward	Room	\$4.00 or \$5.00	\$ 3.00	Oper. Room (Major)	10.00	10.00	Oper. Room (Minor)	5.00	5.00	Delivery room	10.00	10.00	Out-Pat. accident (24 hrs.)	10.00	7.50	Anesthesia (Major \$7.50), minor	5.00	5.00	Laboratory	5.00	3.00	X-ray exam.	10.00	10.00	Basal-metabolism	5.00	-0-	Electro-cardiograms	10.00	-0-	Physio-therapy	10.00	-0-	Oxygen therapy	25.00	20.00	Casts (Material)	10.00	5.00	Pathology	5.00	-0-	Penicillin	10.00	-0-
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Oxygen therapy	25.00	20.00																																															
Casts (Material)	10.00	5.00																																															
Pathology	5.00	-0-																																															
Penicillin	10.00	-0-																																															
DURHAM, N.C.	Same as comprehensive contract in member hospitals except extras are limited to 5 times the room and board allowance.																																																
FARGO, N.D.	\$3.50 for room and board; \$1.50 daily for additional services.																																																

APPENDIX D - 8 (Continued)

NOTES

PHILADELPHIA, PA.	Semi-private, \$12.00 first day.
PROVIDENCE, R.I.	"Comprehensive" contract provides semi-private allowance, "standard" contract provides ward allowance. \$30.00 are allowed for extras.
KINGSPORT, TENN.	\$1.00 additional for nursery care in maternity cases.
RICHMOND, VA.	1 day \$14.00; 2 days, \$18.00; 3 days, \$24.00; out-patient emergency room care (accidents) \$10.00.
SAN JUAN, P.R.	Allows \$10.00 for operating or delivery room, and \$5.00 for anesthesia.
WINNIPEG, MAN.	Higher short-stay rates in non-member hospitals in Manitoba.
TORONTO, ONT.	Not exceeding \$4.50 per day ward, \$6.00 semi-private. Maternity 50%.
MONCTON, N.B.	Including Prince Edward Island, Nova Scotia, and New Brunswick. Benefits provided outside Maritime Provinces - plus x-ray \$10.00 per admission.

APPENDIX D

TABLE 9

PLANS PARTICIPATING IN INTER PLAN SERVICE BENEFIT AGREEMENT FEBRUARY 1, 1947

(Data from the Blue Cross Commission)

NOTE:

Part I - Requests service benefits for their subscribers in other participating Plan areas.

Part II - Will provide their service benefits to subscribers of other participating Plans.

NAME OF PLAN	PART I	PART II
BIRMINGHAM, ALA.	NO	NO
PHOENIX, ARIZ.	NO	NO
LOS ANGELES, CALIF.	NO	NO
OAKLAND, CALIF.	NO	NO
SACRAMENTO, CALIF.	NO	NO
DENVER, COLO.	YES	YES
NEW HAVEN, CONN.	NO	NO
WILMINGTON, DEL.	NO	NO
WASHINGTON, D. C.	NO	NO
JACKSONVILLE, FLA.	YES	YES
ATLANTA, GA.	NO	NO
SAVANNAH, GA.	NO	NO
BOISE, IDAHO	YES	YES
ALTON, ILL.	YES	YES
CHICAGO, ILL.	YES	YES
DANVILLE, ILL.	NO	NO
DECATUR, ILL.	NO	NO
PEORIA, ILL.	YES	YES
ROCKFORD, ILL.	NO	NO
INDIANAPOLIS, IND.	YES	YES
DES MOINES, IA.	YES	YES
SIOUX CITY, IA.	NO	NO
TOPEKA, KAN.	YES	YES
ASHLAND, KY.	YES	YES
LOUISVILLE, KY.	NO	NO
ALEXANDRIA, LA.	YES	YES
BATON ROUGE, LA.	NO	NO
NEW ORLEANS, LA	YES	YES
PORTLAND, ME.	NO	NO
BALTIMORE, MD.	NO	NO
BOSTON, MASS.	YES	YES
DETROIT, MICH.	NO	NO
ST. PAUL, MINN.	NO	NO
KANSAS CITY, MO.	YES*	YES
ST. LOUIS, MO.	YES	YES

Kansas City, re: Part I:

"For direct payment (non-group) members, acceptance wire may state indemnity benefit to be allowed by the 'Host Plan' rather than regular service benefits."

APPENDIX D - 9 (Continued)

NAME OF PLAN	PART I	PART II
HELENA, MONT.	NO	NO
OMAHA, NEB.	NO	YES
CONCORD, N.H.	NO	NO
NEWARK, N.J.	NO	NO
ALBUQUERQUE, N.M.	YES	YES
ALBANY, N.Y.	NO	NO
BUFFALO, N.Y.	YES	YES
JAMESTOWN, N.Y.	NO	NO
NEW YORK, N.Y.	YES	YES
ROCHESTER, N.Y.	NO	NO
SYRACUSE, N.Y.	NO	NO
UTICA, N.Y.	NO	NO
WATERTOWN, N.Y.	NO	NO
CHAPEL HILL, N.C.	NO	YES
DURHAM, N.C.	NO	NO
FARGO, N.D.	NO	NO
AKRON, OHIO	YES	YES
CANTON, OHIO	YES	YES
CINCINNATI, OHIO	YES	YES
CLEVELAND, OHIO	YES	YES
COLUMBUS, OHIO	NO	NO
LIMA, OHIO	YES	YES
PORTSMOUTH, OHIO	YES	YES
TOLEDO, OHIO	NO	YES
YOUNGSTOWN, OHIO	NO	NO
TULSA, OKLA.	NO	NO
PORTLAND, ORE.	YES	YES
ALLENTOWN, PA.	YES	YES
HARRISBURG, PA.	YES	YES
PHILADELPHIA, PA.	YES	YES
PITTSBURGH, PA.	YES	YES
WILKES-BARRE, PA.	YES	YES
PROVIDENCE, R.I.	NO	NO
CHATTANOOGA, TENN.	YES	YES
KINGSPORT, TENN.	NO	NO
DALLAS, TEXAS	YES	YES
SALT LAKE CITY, UTAH	NO	NO
LYNCHBURG, VA.	NO	NO
NEWPORT NEWS, VA.	NO	NO
NORFOLK, VA.	NO	NO
RICHMOND, VA.	NO	NO
ROANOKE, VA.	YES	YES
SEATTLE, WASH.	YES	YES
CHARLESTON, W. VA.	YES	YES
HUNTINGTON, W. VA.	YES	YES
MILWAUKEE, WIS.	YES	YES
SAN JUAN, P.R.	NO	NO
VANCOUVER, B.C.	NO	NO
WINNIPEG, MAN.	NO	NO
MONCTON, N.B.	NO	NO
TORONTO, ONT.	NO	NO
MONTREAL, QUE.	NO	NO

APPENDIX E

Methods and Amounts of Payment by Blue Cross Plans to Member Hospitals for Contract Benefits, December 1, 1946 (Data from the Blue Cross Commission)

P - Private accommodations

W - Ward accommodations

SP - Semi-private accommodations

C - Comprehensive contract

PLAN HEADQUARTERS CITY		TOTAL PAYMENTS FOR SHORT STAY CASES			PER DIEM AFTER SHORT STAY	REMARKS
		1-DAY	2-DAY	3-DAY		
ALABAMA						
BIRMINGHAM	P	\$10.00	\$16.00		\$8.00	50¢ per day extra for OB.
	W	10.00	16.00		6.00	
ARIZONA						
PHOENIX	SP	14.75 (For surgical cases)	18.75	\$22.75	7.25	\$7.25 per day for all medical cases.
CALIFORNIA						
LOS ANGELES	SP	15.00 Graded up to \$104. for 13 days.	24.00	29.25	8.00	\$7.50 per day for med- ical cases.
OAKLAND	SP	Regular charges of each hospital.				\$7.00 per day flat for medical cases.
SACRAMENTO	SP	Regular charges of each hospital (Limit room allowance \$5. per day)				
COLORADO						
DENVER	C	\$6.75 per day plus extras.				See notes.
CONNECTICUT						
NEW HAVEN	SP	\$6.00 allowance for board and room plus equal per diem schedule for extras.				See notes.
DELAWARE						
WILMINGTON	SP	18.20 (\$8.20 per day additional thru 30 days)			8.10	
D. C.						
WASHINGTON	SP	15.00 Graded up to \$91. for 14 days.	20.00	27.00	6.50	See notes.
FLORIDA						
JACKSONVILLE	W	Regular charges of each hospital.				
GEORGIA						
ATLANTA	P	20.00	25.00	30.00	9.00	
	W	16.00	20.00	24.00	7.00	
SAVANNAH	P	15.00	20.00	25.00	7.00	See notes.
	SP	12.00	15.00	18.00	5.00	
IDAHO						
BOISE	W	\$5.00 per day for board and room; detailed uniform fee schedule for special services.				
ILLINOIS						
ALTON	SP	6.40 per day for all stays.				Dependents - \$5.40 per day.
CHICAGO	SP	Cost or charges, whichever is the lower.				See notes.

APPENDIX E (Continued)

P - Private accommodations W - Ward accommodations
 SP - Semi-private accommodations C - Comprehensive contract

PLAN HEADQUARTERS CITY		TOTAL PAYMENTS FOR SHORT STAY CASES			PER DIEM AFTER SHORT STAY	REMARKS
		1-DAY	2-DAY	3-DAY		
ILLINOIS (Cont.)						
DANVILLE	SP	8.00	15.00		5.75	
DECATUR	SP	6.00 per day for all stays, adjusted annually to 100% of charges.				
PEORIA	SP	90% of charges; maximum - \$8.50; minimum - \$6.00				See notes.
ROCKFORD	SP	Regular charges for contract benefits.				
INDIANA						
INDIANAPOLIS	SP &W	Regular charges for contract benefits.				
IOWA						
DES MOINES	SP	90% of regular charges paid currently; semi-annual adjustment to 100% if total earnings permit.				
SIOUX CITY	SP	12.00	16.00	20.00	5.00	
		Graded up to \$60. for ten days. Pay \$10. anesthetic fee in addition to per diem.				
KANSAS						
TOPEKA	SP	11.00	16.50	20.00	5.75	
		Adjusted "up" to regular charges.				
KENTUCKY						
ASHLAND	SP	Regular charges for contract benefits (maximum on room service).				
LOUISVILLE	SP	Regular charges for contract benefits.				
LOUISIANA						
ALEXANDRIA	SP	7.25 per day for all cases, plus 50% of X-ray bill and \$25. allowance on oxygen therapy.				\$12.00 for one day surgical cases.
BATON ROUGE	P	7.00 per day for all stays (Dependents \$5.25)				
	W	5.00 per day for all stays (Dependents \$4.00)				See notes.
NEW ORLEANS	P	15.00	32.00	42.00	7.00	
		Graded up to \$90. for nine days.				
	SP	12.00	26.00	34.00	4.50	
		Graded up to \$64. for nine days.				For dependent rates see Notes.
MAINE						
PORTLAND	SP	12.00	16.00	20.00	6.00	
		Adjusted periodically on basis of costs not to exceed an established ceiling.				
MARYLAND						
BALTIMORE	SP	15.00	22.00	28.00	6.25	
		Graded up to \$85. for 13 days				See notes.
MASSACHUSETTS						
BOSTON	SP	Regular charges of each hospital; ceiling on board and room.				See notes.

APPENDIX E (Continued)

P - private accommodations W - Ward accommodations
 SP - Semi-private accommodations C - Comprehensive contract

PLAN HEADQUARTERS CITY	TOTAL PAYMENTS FOR SHORT STAY CASES			PER DIEM AFTER SHORT STAY	REMARKS
	1-DAY	2-DAY	3-DAY		
MICHIGAN					
DETROIT	SP &W	90% of regular charges paid currently, adjusted "up" to Costs or charges, whichever is the lower.			
MINNESOTA					
ST. PAUL	SP	90% of regular charges paid currently, adjusted "up" to 100% if total income permits. Ceiling on room service allowances.			
MISSOURI					
KANSAS CITY	SP	12.00 (For subscribers)	15.00	7.50	See notes.
ST. LOUIS	SP	6.40 per day for all stays. (For subscribers)			See notes.
MONTANA					
HELENA	SP	11.50	17.25	23.00	5.75
NEBRASKA					
OMAHA	SP	Regular charges of each hospital less 3%. Room charge limited to \$5.00 per day.			
NEW HAMPSHIRE					
CONCORD	SP	20.00	25.00	30.00	7.50
		Graded up to \$40. for five days. Plus 50% regular charges for medications and oxygen; adjusted "down" to regular charges.			
NEW JERSEY					
NEWARK	SP	18.00	22.00	31.00	6.00
		Graded up to \$49 for five days. Graded up to \$77 for nine days. Adjusted "up" to regular charges.			Payments are based on calendar days. See notes.
NEW MEXICO					
ALBUQUERQUE	SP	10.50	16.00	20.50	6.00
NEW YORK					
ALBANY	SP	15.00	20.00	24.00	6.00
		Adjusted to 97% of regular charges with ceiling of \$7. per day when billings exceed \$6. per day.			
BUFFALO	SP &W	97% of regular charges not to exceed average of \$7.50 per day for semi- private and \$6.25 for ward cases.			
JAMESTOWN	P SP W	17.00	24.00	30.00	
		Graded up to \$75 for ten days; graded up to \$133 for 21 days.			
		15.00	22.00	27.00	
		Graded up to \$65. for ten days; graded up to \$112. for 21 days. Adjusted "down" to 97% of charges.			
NEW YORK	SP	15.00	25.00	34.00	6.00
		Graded up to \$85. for ten days. Adjusted "up" to 97% of charges.			
ROCHESTER	SP	Equal per diem payments for groups of hospitals.			See notes.

APPENDIX E (Continued)

P - Private accommodations W - Ward accommodations
 SP - Semi-private accommodations C - Comprehensive contract

PLAN HEADQUARTERS CITY		TOTAL PAYMENTS FOR SHORT STAY CASES			PER DIEM AFTER SHORT STAY	REMARKS
		1-DAY	2-DAY	3-DAY		
NEW YORK (Cont.)						
SYRACUSE	SP	12.35	20.50			
		7.00 per day for ten days stay.				
UTICA	SP	11.00			6.00	See notes.
WATERTOWN	SP	14.00	18.00	18.00	6.00	5% additional to Watertown hospitals.
NORTH CAROLINA						
CHAPEL HILL	SP					
	&W	Regular charges of each hospital.				
DURHAM	SP					
	&W	Regular charges of each hospital.				
NORTH DAKOTA						
FARGO	SP	9.25	14.25	19.25	5.00	\$24.25 for four days stay.
		Adjusted, if necessary, "up" to 92% of billing.				
OHIO						
AKRON	SP					
	&W	Regular charges of each hospital				
CANTON	SP	Varied payments to individual hospitals				
	&W	based on per diem costs.				
		See notes.				
CINCINNATI	SP	Regular charges of each hospital with				
	&W	ceiling based upon 1945 costs.				
CLEVELAND	SP	per diem costs to individual hospitals.				
	&W	(Information not verified)				
COLUMBUS	SP	Regular charges of each hospital with				
	&W	ceilings.				
		See notes.				
LIMA	SP	per diem costs for individual hospitals based on Industrial Commission data.				
		Maximum - \$6.75; minimum - \$6.00.				
PORTSMOUTH						
	P					
	&W	Regular charges.				
TOLEDO	SP	8.00 per day for all stays.				
	W	7.00 per day for all stays.				
YOUNGSTOWN	SP					
	&W	Regular charges of each hospital.				
OKLAHOMA						
TULSA	SP	10.00	15.00		6.00	
		Adjusted annually "up" to 97% of charges dependent upon total net income of Plan.				
OREGON						
PORTLAND	W	14.00	21.00	27.50	7.00	
		Adjusted "down" to regular charges.				
PENNSYLVANIA						
ALLENTOWN	SP	14.00	21.00	27.75		
		Graded up to \$75 for 10 days stay; graded up to \$165. for 30 days stay.				

APPENDIX E (Continued)

P - Private accommodations W - Ward accommodations
 SP - Semi-private accommodations C - Comprehensive contract

PLAN HEADQUARTERS CITY		TOTAL PAYMENTS FOR SHORT STAY CASES			PER DIEM AFTER, SHORT STAY	REMARKS
		1-DAY	2-DAY	3-DAY		
PENNSYLVANIA (Cont.)						
HARRISBURG	SP	Regular charges of each hospital, less 2%.				
PHILADELPHIA	SP	15.00	21.50	28.50		See notes.
		Graded up to \$75. for ten days; graded up to \$180. for 30 days.				
PITTSBURGH (Effective 1/1/47)	SP	18.00	21.00	22.50	7.00	
		Graded up to \$70. for ten days.				
	W	14.00	17.00	18.00	5.50	See notes.
		Graded up to \$60. for ten days.				
WILKES-BARRE	SP	13.00	18.00	21.00		See notes.
		Pay charges with ceiling of \$8.00 per day before deducting 5% (returned annually if reserves justify.)				
RHODE ISLAND						
PROVIDENCE	SP	18.00	26.00	34.00	8.00	See notes.
		(Maxima) Up to \$6. per day for room service. Payments based on regular charges up to above maxima with minimum guaranteed payment of \$7. per day. Graded up to \$93. for ten days; graded up to \$200. for 25 days.				
TENNESSEE						
CHATTANOOGA	SP	Regular charges of each hospital.				
KINGSPORT	W	per diem cost plus 50¢. This is a one hospital plan.				See notes.
TEXAS						
DALLAS	SP	\$5.00 paid currently, adjusted to 100% of charges provided total income of Plan permits. Ceiling of \$5. per day for board and room service.				
UTAH						
SALT LAKE CITY	SP	per diem costs of individual hos- pitals.				
VIRGINIA						
LYNCHBURG	P	14.00	20.00	24.00	5.50	
		Graded up to \$77. for 14 days.				
NEWPORT NEWS	SP	6.50 per day for all stays.				
NORFOLK	P	15.00	22.50	30.00	8.50	Flat per diem for non-operative cases.
	W	12.00	18.00	24.00	7.00	
RICHMOND	SP	14.00	18.00	24.00	5.25	See notes.
		Graded up to \$68.75 for 11 days stay; graded up to \$131.25 for 21 days. Adjusted "up" on basis of hospital costs or "down" to regular charges.				

APPENDIX E (Continued)

P - Private accommodations W - Ward accommodations
 SP - Semi-private accommodations C - Comprehensive contract

PLAN HEADQUARTERS CITY		TOTAL PAYMENTS FOR SHORT STAY CASES			PER DIEM AFTER SHORT STAY	REMARKS
		1-DAY	2-DAY	3-DAY		
VIRGINIA (Cont.)						
ROANOKE	SP	15.00	20.00	24.00	6.00	Graded up to \$92.25 for 15 days.
WASHINGTON						
SEATTLE	W	Regular charges for each hospital; ceiling of \$7.50 on room service.				
WEST VIRGINIA						
CHARLESTON	SP	Regular charges for each hospital; ceiling on room service. Uniform payments to all hospitals for special services.				
HUNTINGTON	SP	\$3.50 maximum toward room service; uniform payments to all hospitals for special services.				
WISCONSIN						
MILWAUKEE	SP	97% of regular charges.				
PUERTO RICO						
SAN JUAN	SP	\$4.00 per day for room service; plus \$10. for operating room and \$5. for anesthesia.				
CANADA						
BRITISH COLUMBIA						
VANCOUVER	W	Regular charges for each hospital.				
MANITOBA						
WINNIPEG	SP &W	95% of regular charges for each hospital according to fee schedules registered with Association.				
MARITIME PROVINCES						
MONCTON, N. B.	SP &W	Rates being adjusted				
ONTARIO						
TORONTO	SP &W	Regular charges for each hospital.				
QUEBEC						
MONTREAL	SP	Regular charges for each hospital accord- ing to fee schedule filed with Association.				

APPENDIX E (Continued)

NOTES

COLORADO
DENVER

For the new comprehensive contract (the only one listed here) the basic per diem payment is:

"\$6.75 per day and in addition we will pay all laboratory, Basal Metabolism and Electrocardiogram charges, Anesthesia up to \$10.00 and X-ray up to \$15.00. All of these extra charges will be paid on the basis of the Medical Service Plan fee schedule."

For a number of rural hospitals the basic per diem payment is \$6.25 plus extras.

CONNECTICUT
NEW HAVEN

The allowances for extras may be calculated from the following: one day - \$14.00 with \$1.00 per day increase during the first seven days and 50¢ additional increase from eight to 21 days. The average adjusted semi-annually to a minimum of \$2.60 per day for each hospital.

DELAWARE
WILMINGTON

The rates shown apply to three of the large hospitals in Wilmington. The other hospitals are now being paid regular charges, but revision is under consideration

WASHINGTON
DISTRICT OF COLUMBIA

Additional payment of \$1.50 per day for nursery care.

GEORGIA
SAVANNAH

\$10.50 per day for eight days for Caesarean sections.

ILLINOIS
CHICAGO

For each hospital there are different payments equal to 110% of costs, or 97% of charges of average billings, whichever is the lower; except where the amount of \$8.50 falls between average costs and average charges in which case the payment is \$8.50.

PEORIA

Current payments based on 90% of previous six months' average charges for contract benefits, adjusted semi-annually to 97% of current charges with minimum of \$6.00 and maximum of \$8.50.

LOUISIANA
BATON ROUGE

One day surgical rates:

	<u>SUBSCRIBER</u>	<u>DEPENDENT</u>
Private:	\$12.00	\$10.25
Ward	10.00	9.00

(Information not verified)

NEW ORLEANS

DEPENDENTS:

	<u>1-day</u>	<u>2-day</u>	<u>3-day</u>	<u>Per diem after short stay</u>
P.	\$12.50	\$27.00	\$34.50	\$4.50
	(Graded up to \$67.50 for nine days)			
SP	11.00	24.00	31.00	3.50
	(Graded up to \$55.00 for nine days)			

MARYLAND
BALTIMORE

In the near future the Maryland plan will adopt a policy of adjusting hospital payments to average charges or per diem costs of contract benefits, whichever is the lower.

MASSACHUSETTS
BOSTON

Ceiling on room services payment allowances is \$7.50 for hospitals approved for residencies and training of internes; \$7.00 for those approved by the American College of Surgeons; and \$6.50 for all others.

MISSOURI
KANSAS CITY

DEPENDENTS:

	<u>1-day</u>	<u>2-day</u>	<u>Per diem after short stay</u>
SP	\$10.00	\$12.00	\$6.00

Subscription rates and hospital payments are in process of adjustment.

ST. LOUIS

Subscription rates and hospital payments are in process of adjustment. Dependent - \$5.40 per day. Subscriber maternity - \$7.40 per day.

NEW JERSEY
NEWARK

Current payments are the "schedule" or actual charges for each hospital whichever is the lower. The total is adjusted semi-annually to bring the total payments "up or down" to the schedule or actual charges for all cases, whichever is lower.

APPENDIX E (Continued)

NOTES

**NEW YORK
ROCHESTER**

Hospitals are classified in three groups according to scope of facilities and services. Group in Rochester being paid \$8.50 per day, other hospitals paid \$7.75 and \$7.25 per day.

UTICA

Amounts here listed are for payments on behalf of subscriber under the semi-private contract. Payments are somewhat less for dependents who are required to pay a certain amount per day. The rate of reimbursement for ward cases is lower.

**OHIO
CANTON**

Participating hospitals receive \$9.25 or \$8.75 per day for both ward and semi-private contracts. Co-operating hospitals receive \$7.50 per day for semi-private and \$6.50 per day for ward.

COLUMBUS

Ceilings of average payments are limited to \$7.00 for ward care and \$7.90 for semi-private care.

**PENNSYLVANIA
PHILADELPHIA**

In addition, the Association will reimburse the hospital for drugs and oxygen therapy during any one admission in excess of \$20.00 upon receipt of an itemized account allowing 50% mark-up on cost of drugs and 100% on oxygen.

PITTSBURGH

No payments are to exceed 100% of billings, adjusted on a quarterly and annual basis.

WILKES-BARRE

Additional payments are allowed for penicillin, oxygen and physiotherapy.

**RHODE ISLAND
PROVIDENCE**

The amount of special charges allowed are based upon length of stay. For example: one day - \$12.00; ten days - \$33.00; twenty days - \$45.00. The minimum total payment is \$7.00 per day including special services.

**TENNESSEE
KINGSPORT**

Payments apply to first two participants on contract, other participants allowed \$1.00 per day less.

**VIRGINIA
RICHMOND**

Where the costs of one hospital are higher than the average as much as ten per cent may be added to the basic scale of payment. No hospital may receive more than the regular charges.

APPENDIX F

PRINCIPLES GOVERNING THE RELATIONSHIP BETWEEN HOSPITALS AND BLUE CROSS PLANS

(ADOPTED BY THE HOUSE OF DELEGATES OF THE AMERICAN
HOSPITAL ASSOCIATION, OCTOBER, 1946.)

The following commentary and recommendations define insofar as possible fundamental principles which may be used to govern the relationship between Blue Cross plans and hospitals. While the major portion of this report has been devoted to establishing a pattern intended to fit the contractual needs of Blue Cross Plans and hospitals, the responsibility of both agencies to subscribers of nonprofit insurance plans has not been overlooked. It is believed that the general public stand to benefit materially only if satisfactory working relations are established between plans and hospitals.

The Blue Cross movement was motivated by the desire of hospitals to make service more easily available to the public on a prepayment basis. Blue Cross plans were organized usually under sponsorship of the hospitals in the area, but as distinct entities with independent boards of trustees. This form of organization places Blue Cross plans in the position of an intermediary agency representing the interests of both the hospitals and the public. Under their present method of operation, full cooperation of affiliated hospitals must be obtained to insure the continued existence and development of Blue Cross plans. For this reason, primarily, Blue Cross plans must demonstrate a sympathetic understanding of hospital needs and, conversely, hospitals must recognize the many problems which confront Blue Cross in their dealings with subscribers and in meeting competition.

FUNDAMENTAL PRINCIPLES

TO BE ACCEPTED BY HOSPITALS:

1. The executives and members of the governing boards of hospitals must accept the obligation of providing to the subscribers of Blue Cross plans proper facilities and good service.
2. The hospitals, as agencies organized to render service to the public, must of necessity receive a fair and equitable rate of payment for services rendered to subscribers of Blue Cross plans.
3. Hospitals should not expect to receive rates of payment from Blue Cross plans for basic services provided to subscribers in excess of the cost of such services, cost to include an allowance for depreciation of buildings and equipment and allowances for other contingencies as determined by mutual agreement between hospitals and Blue Cross plans at the local level.
4. Executives and members of the governing boards of hospitals should not expect to receive rates of payment for services rendered to subscribers beyond 100 percent of the average gross earnings at established rates for all private patients occupying similar accommodations in the hospital.
5. Where the contract does not provide for all-inclusive services, the hospital shall not expect to be paid by Blue Cross for those services not included in the terms of the Blue Cross contract.

6. Executives and members of the governing boards of hospitals must assume the obligation of operating their institutions on an efficient, businesslike basis.

7. Executives and members of governing boards of hospitals must assume the obligation of keeping proper financial and statistical records in accordance with accepted procedures in order that information may be developed which may be used as a basis for establishing an equitable rate of payment.

TO BE ACCEPTED BY BLUE CROSS PLANS:

1. Executives and members of the governing boards of Blue Cross plans should expect that the quality of service rendered by hospitals should be commensurate with the payment made to such hospitals.

2. Executives and members of the governing boards of Blue Cross plans should not expect the executives and members of the governing boards of hospitals to accept a rate of payment for services rendered to subscribers which would thus force the hospital to use trust and other funds to make up the difference between payments received and the cost of rendering service required under the Blue Cross contract.

3. Executives and members of the governing boards of Blue Cross plans should not expect the executives and members of the governing boards of hospitals to depend upon income from private patients, not subscribers to a plan, to provide operating funds to make up losses of income sustained by virtue of service rendered to plan subscribers.

4. Executives and members of the governing boards of Blue Cross plans should not adopt policies that are inconsistent with the operating and fiscal policies of hospitals.

5. Blue Cross plans, as nonprofit organizations, must accept the obligation of operating on a businesslike, efficient basis, and must assume the responsibility for keeping proper accounting and statistical records concerning their operations and submit detailed reports to affiliated hospitals periodically.

METHOD OF REIMBURSEMENT TO HOSPITALS

Insofar as it is known, there are three general methods followed by Blue Cross plans in paying for services rendered to their subscribers:

1. A flat rate for all or groups of hospitals.

2. A rate of payment with some relation to cost and with modifications in different areas.

3. Payment at established rates for accommodations occupied with variations according to the locality in which the plan is in effect.

Any plan adopted for reimbursement of the hospitals for services rendered to subscribers should be developed on a cooperative basis by representatives of the hospitals and the Blue Cross plans. Hospitals and Blue Cross plans shall both supply adequate financial and service data so that the principles enunciated in the preceding portion of this statement can be taken into proper consideration.

The hospitals, in discussing rate of reimbursement should keep in mind that the plan must have reserve funds consistent with its needs and the legal requirements of the state in which it operates. Blue Cross plans should also keep in mind the hospitals' need for reserve funds, even though such reserves are not required by law. It follows that adequate reserves held by Blue Cross plans will not benefit subscribers if hospitals, due to inadequate working capital, find it necessary to curtail or discontinue service. In considering

these matters it must be borne in mind that the shift to contractual service within the hospital population may lessen the philanthropic support which hospitals have enjoyed for inpatient service.

Due to the varying views and conditions, it is doubtful that any plan can be devised at the present time which would be entirely satisfactory to every area and section of the country. Therefore, the following suggestions are made:

In the development of any rate structure by the representatives of hospitals and Blue Cross plans, the group should insist upon having adequate financial and service data concerning the operation of hospitals and Blue Cross plans.

That officially appointed representatives of the Blue Cross plans meet with officially appointed hospital representatives in any given area for a free and frank expression of opinion on the rates to be paid to hospitals and the principles and the formula on which such rates would be established. This group of representatives to give full recognition to the principles set forth to be accepted by hospitals and by Blue Cross plans. It should be fully understood that any conclusion reached by the representatives of the two organizations, plans and hospitals, should not become effective until approved by at least 50 percent of the member hospitals representing at least three-fourths of the patient days of service rendered Blue Cross subscribers during the past 12 months. It would be further agreed that any rate approved should be reviewed at least once a year, and preferably every six months' period for such adjustments as might be necessary to protect the interests of subscribers, hospitals and plans.

1. If the area of operation of a Blue Cross plan should be on a state-wide basis, then the groups selected should be representatives of the various districts of the state, including representatives from the state hospital association, and the Blue Cross plan representatives should be selected from various sections of the state.

2. If the scope of operation of the Blue Cross plan is for a single city or county, or a group of adjoining counties, then the representatives should be chosen from executives and members of the governing boards of the member hospitals, and the plan should select representatives from their executives and members of the governing boards.

3. If any organization representing the hospitals is in a position to assume the obligation of development of rates, assistance should be sought from such group, provided the agency is acceptable to both the hospitals and the Blue Cross plan.

RELATION OF HOSPITAL PAYMENTS TO SUBSCRIPTION RATES

The Blue Cross plans and the hospitals should assume the responsibility of educating the public to pay a subscription rate sufficient to meet the necessary cost of good hospital care.

The thought must always be kept in mind that both Blue Cross plans and hospitals must be financially strong, but not at the expense of each other. With the increase in Blue Cross cases and other contract cases, hospital income from other than contract cases will be increasingly limited and it is obvious that hospitals cannot operate at a loss for any considerable time. Likewise, there is a limit to what the plans can pay hospitals, as they are

regulated by statute so far as reserves and certain conditions are concerned. The interests of the subscriber are of great importance. The subscriber must understand that as hospital costs increase, subscription rates must be increased proportionately and, further, that in many instances present subscription rates are not adequate to meet current hospital costs. In meeting these requirements subscribers, hospitals and Blue Cross plans must recognize the interests of each other and full cooperation and understanding must prevail.

APPENDIX G

MODEL LAW TO ENABLE THE FORMATION OF NON-PROFIT HOSPITAL AND/OR MEDICAL SERVICE PLANS, PROPOSED BY THE BLUE CROSS COMMISSION

SCOPE 1. Any corporation organized not for profit under the General Corporation Act of the State of for the purpose of establishing, maintaining and operating a non-profit corporation, whereby hospital and/or medical service may be provided by a group of hospitals and/or physicians, with which such corporation has a contract for such purpose, to such of the public as become subscribers to said corporation under a contract which entitles each subscriber to certain hospital and/or medical care, shall be governed by this act and shall be exempt from all other provisions of the insurance laws of this state, unless otherwise specifically provided herein.

INCORPORATION 2. The articles of incorporation of every such corporation, and amendments thereto, shall be submitted to the Department of Insurance, whose approval thereof shall be endorsed thereon before the same are filed with the Secretary of State; provided, however, that if the articles of incorporation of any such corporation shall have been filed with the Secretary of State prior to the effective date of this statute, the approval thereof by the Department of Insurance shall be evidenced by a separate instrument in writing filed with the Secretary of State.

DIRECTORS 3. The Directors of such corporation must at all times include representatives of the following groups: administrators or trustees of hospitals which have contracted with such corporation to render hospital service to the subscribers; licensed physicians who have contracted with such corporation to render medical service to the subscribers; general public exclusive of hospital representatives and physicians. (The committee recognizes that the proportions of the groups mentioned may vary with the special character of the program offered by each corporation established under this legislation.)

CONTRACTS 4. Such corporation may enter into contracts for the rendering of hospital and/or medical service to the subscribers only with hospitals approved for participation by the Department of Insurance and with licensed physicians. (The corporation may include in the conditions for hospital participation certain professional and administrative standards, subject at all times to approval by appropriate regulatory bodies, such as the Health or Welfare department in consultation with the Department of Insurance.)

All contracts issued by such corporation to the subscribers shall constitute direct obligations of the hospitals and/or physicians with which such corporation has contracted for hospital and/or medical service. The rates charged to the subscribers for hospital and/or medical service and the rates of payment by such corporation to the contracting hospitals and/or physicians at all times shall be subject to the approval of the Department of Insurance.

LICENSURE 5. A corporation subject to the provisions of this act may issue contracts only when the Department of Insurance has by formal certificate or license authorized it to do so. Application for such certificate of authority or license shall be made on forms to be supplied by the Department of In-

surance, containing such information as it shall deem necessary. Each application for such certificate or license shall be accompanied by copies of the following documents: (a) certificate of incorporation; (b) by-laws; (c) proposed contracts between the corporation and participating hospitals and/or physicians showing terms under which hospital and/or medical service is to be furnished to subscribers; (d) contracts to be issued to subscribers showing the benefits to which they are entitled; (e) a table of the rates to be charged to the subscribers; (f) financial statement of the corporation, including the amounts of contribution paid or agreed to be paid to the corporation for working capital and the name or names of each contributor and the terms of each contribution.

The Department of Insurance shall issue a certificate of authority or license upon payment of a fee of \$.....and upon being satisfied on the following points:

(a) That the applicant is established as a bona fide non-profit hospital and/or medical service corporation.

(b) That the contract between the applicant and the participating hospitals and/or physicians obligate each hospital and/or physician party to render service to which each subscriber may be entitled under the terms and conditions of the contract issued to the subscribers.

(c) That the rates to be charged and benefits to be provided are fair and reasonable.

(d) That amounts provided as working capital of the corporation are repayable only out of earned income paid and payable for operating expenses and hospital and/or medical expenses, and such reserve as the Department of Insurance may deem adequate.

(e) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.

REPORTS 6. Every such corporation shall annually on or before the first day of March file in the office of the Department of Insurance a statement verified by at least two of the principal officers of said corporation showing its condition on the 31st day of December, then next preceding, which shall be in such form and shall contain such matters as the Department shall prescribe.

VISITATION 7. The Department of Insurance may appoint any Deputy or Examiner or other person who may have the power of visitation and examination into the affairs of any such corporation and free access to all of the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents or employees or other persons in relation to the affairs, transactions and conditions of the corporation.

The Insurance Department shall conduct an examination of each such corporation, at least every three years, and the costs of such regular or other special examinations shall be borne by the corporation.

EXPENSES 8. All acquisition and administrative expenses in connection with such hospital and/or medical service corporation shall at all times be subject to control by the Department of Insurance.

INVESTMENTS 9. The funds of any corporation subject to the provisions of this Act shall be invested only in securities permitted by the law of this state for the investment of assets of life insurance companies.

DECISIONS 10. Any decision and finding of the Department of Insurance made

under the provisions of this act shall not be any bar to constituted legal procedure in a court of competent jurisdiction.

DISSOLUTION 11. Any dissolution or liquidation of a corporation subject to the provisions of this Act shall be conducted under the supervision of the Department of Insurance which shall have all power with respect thereto under the provisions of law with respect to the dissolution and liquidation of insurance companies.

TAXATION 12. Every corporation subject to the provisions of this Act is hereby declared to be a charitable and benevolent institution, and the corporation shall be exempt from every state, county, and municipal tax.

APPENDIX H

FINANCIAL DATA, BLUE CROSS PLANS, 1945

PLAN	MONTHS OF OPER- ATION	NUMBER OF PARTICIPANTS 1-1-46	TOTAL INCOME 1945	PERCENT OF TOTAL INCOME USED FOR			AVERAGE ADMIN. COST PER PARTIC.	TOTAL RESERVES 12-31-45	RESERVE PER PARTIC- 12-31-45	RESERVE MONTHS OF HOSP- ITALIZA- TION
				HOSP- ITALI- ZATION	ADMINIS- TRATION	RESERVES				
			\$	%	%	%	\$	\$	\$	(MONTHS)
500,000 OR MORE PARTICIPANTS										
NEW YORK, N. Y.	128	2,194,256	16,418,699	79.6	12.9	7.6	1.07	11,075,448	5.05	9.2
MASSACHUSETTS	99	1,431,985	8,630,109	83.0	13.5	3.6	0.97	3,200,073	2.23	4.5
MICHIGAN	82	1,248,000	9,095,864	98.3	10.5	-8.8	0.77	325,961	0.26	0.4
PITTSBURGH, PA.	96	851,245	5,560,017	78.8	10.5	10.8	0.73	1,941,701	2.28	5.0
CLEVELAND, OHIO	136	828,979	5,402,595	92.8	7.0	0.1	0.46	862,304	1.04	2.1
CHICAGO, ILL.	108	821,092	6,102,636	83.6	12.7	3.7	1.00	1,977,957	2.41	4.4
PHILADELPHIA, PA.	86	815,771	5,703,965	75.6	11.0	13.4	0.83	2,780,885	3.41	7.1
NEW JERSEY	156	796,633	5,971,516	75.2	12.6	12.2	1.04	2,961,667	3.72	7.1
MINNESOTA	150	638,119	3,290,065	81.8	11.1	7.1	0.59	1,138,012	1.78	5.0
ST. LOUIS, MO.	117	596,802	3,315,294	77.6	12.5	9.8	0.78	1,738,933	2.91	7.3
CONNECTICUT	107	525,000	3,855,471	93.6	7.2	-0.7	0.57	1,075,230	2.05	3.3
CINCINNATI, OHIO	76	503,663	3,697,895	83.8	9.5	6.7	0.70	989,490	1.96	3.8
SUBTOTALS - 12 PLANS		11,251,545	77,044,126	83.6	11.4	5.0	0.84	30,067,661	2.67	5.2
200,000 - 500,000 PARTICIPANTS										
WISCONSIN	72	420,817	2,119,359	83.2	10.8	6.0	0.65	330,581	0.79	1.9
BUFFALO, N. Y.	108	366,590	2,217,639	86.2	13.4	0.4	0.81	493,006	1.34	3.1
RHODE ISLAND	76	341,272	2,047,139	68.7	8.8	22.6	0.61	869,334	2.55	6.4
MARYLAND	98	332,750	2,368,192	65.0	8.3	26.7	0.64	1,947,869	5.85	13.9
COLORADO	87	314,952	1,717,581	82.8	10.1	7.0	0.52	636,191	2.02	5.0
ROCKFORD, ILL.	80	268,126	696,007	81.0	13.6	5.4	0.39	153,494	0.57	2.9
ROCHESTER, N. Y.	127	266,274	1,822,219	84.3	11.5	4.2	0.80	724,929	2.72	5.6
CHAPEL HILL, N. C.	121	257,000	1,385,813 ^{a/}	77.0 ^{a/}	19.4 ^{a/}	3.6 ^{a/}	1.10 ^{a/}	465,586 ^{a/}	1.81 ^{a/}	5.0 ^{a/}
DES MOINES, IOWA	72	237,091	1,615,389	76.2	14.1	9.7	1.09	164,860	0.70	1.4
DISTRICT OF COLUMBIA	139	235,000	1,644,034	75.1	12.5	12.4	0.93	1,393,029	5.93	12.9
TOLEDO, OHIO	93	224,918	1,435,422	84.6	8.8	6.6	0.58	451,004	2.01	4.4
HARRISBURG, PA.	94	200,575	1,194,716	80.2	11.1	8.7	0.76	500,173	2.49	5.4
SUBTOTALS - 12 PLANS		3,465,365	20,263,510	78.2	11.6	10.2	0.74	8,130,056	2.35	5.7
100,000 - 200,000 PARTICIPANTS										
SYRACUSE, N. Y.	120	189,192	1,140,093	79.7	12.0	8.2	0.76	605,729	3.20	7.6
YOUNGSTOWN, OHIO	94	178,683	1,001,060	89.7	8.2	2.1	0.48	353,005	1.98	4.5

^{a/} Combined data for hospital and medical contracts.

APPENDIX H (Continued) Financial Data, Blue Cross Plans, 1945

PLAN	MONTHS OF OPERATION	NUMBER OF PARTICIPANTS 1-1-46	TOTAL INCOME 1945	PERCENT OF TOTAL INCOME USED FOR			AVERAGE ADMIN. COST PER PARTIC.	TOTAL RESERVES 12-31-45	RESERVE PER PARTIC. 12-31-45	RESERVE MONTHS OF HOSPITALIZATION
				HOSPITALIZATION	ADMINISTRATION	RESERVES				
100,000 200,000 PARTICIPANTS (CONTINUED)			\$	%	%	%	\$	\$	\$	(MONTHS)
KANSAS	42	152,071	676,963	83.6	16.2	0.2	0.98	31,944	0.21	0.5
ALABAMA	117	141,066	1,078,336 ^{a/}	62.9 ^{a/}	16.9 ^{a/}	20.2 ^{a/}	1.32 ^{a/}	765,924 ^{a/}	5.43 ^{a/}	13.2 ^{a/}
INDIANA	16	140,495	683,451	84.9	18.0	-2.9	1.65	2,511	0.02	0.03
MAINE	86	140,000	843,301	77.9	11.0	11.1	0.75	297,590	2.13	4.8
TEXAS	79	139,684	876,204	74.6	20.2	5.2	1.40	144,879	1.04	2.4
LOS ANGELES, CALIF.	94	137,799	1,129,550	77.3	19.0	3.6	1.75	324,184	2.35	4.0
ALBANY, N. Y.	112	137,325	1,037,366	76.5	8.6	14.9	0.71	827,974	6.03	11.6
COLUMBUS, OHIO	85	131,685	874,122	75.5	10.9	13.7	0.72	497,933	3.78	9.2
KANSAS CITY, MO.	90	130,617	821,858	79.4	16.2	4.4	1.10	383,224	2.93	6.5
LOUISVILLE, KY.	89	129,103	597,309	86.9	14.7	-1.6	0.80	133,676	1.04	2.6
NEW HAMPSHIRE-VERMONT	37	125,442	659,602	77.9	14.5	7.6	0.95	129,858	1.04	2.4
WILKES-BARRE, PA.	85	125,177	721,930	71.8	12.1	16.0	0.82	359,701	2.87	7.2
OAKLAND, CALIF.	108	124,703	1,225,553 ^{a/}	74.9 ^{a/}	16.2 ^{a/}	9.0 ^{a/}	1.77 ^{a/}	695,438 ^{a/}	5.58 ^{a/}	8.2 ^{a/}
OKLAHOMA	68	122,261	591,092	76.1	18.5 ^{a/}	5.4	1.05	119,823	0.98	2.7
DURHAM, N. C.	149	118,668	319,518 ^{a/}	65.1 ^{a/}	29.3 ^{a/}	5.7 ^{a/}	2.41 ^{a/}	231,454 ^{a/}	1.95 ^{a/}	4.3 ^{a/}
RICHMOND, VA.	123	117,004	795,725	69.4	16.8	13.7	1.32	366,190	3.13	7.0
AKRON, OHIO	108	116,686	786,134	103.3	6.5	-9.8	0.47	136,533	1.17	1.9
DELAWARE	122	110,557	660,876	87.0	12.0	1.0	0.76	404,931	3.66	8.0
UTICA, N. Y.	107	108,159	593,376	74.8	15.3	9.9	0.86	238,416	2.20	6.3
ALLENSTOWN, PA.	123	104,508	709,300	69.9	10.4	19.7	0.78	376,914	3.61	8.2
PEORIA, ILL.	109	104,016	612,468	88.7	12.8	-1.5	0.85	76,810	0.74	1.5
NEW ORLEANS, LA.	143	104,000	627,360	78.0	17.6	4.4	0.96	440,723	4.24	12.1
SUBTOTALS - 24 PLANS		3,128,901	19,662,547	78.1	14.8	7.2	1.04	7,945,364	2.54	5.5
UNDER 100,000 PARTICIPANTS										
CANTON, OHIO	87	88,723	512,147	95.8	7.0	-2.8	0.42	214,694	2.42	5.0
WASHINGTON	43	87,483	583,790	86.3	17.9	-4.1	1.39	-3,047	-0.03	-0.1
ALTON, ILLINOIS	91	79,284	377,814	82.4	9.8	7.8	0.52	84,954	1.07	3.0
NEBRASKA	83	57,636	309,292	72.2	19.6	8.2	1.24	70,916	1.23	3.2
OREGON	43	50,131	378,368	78.0	17.6	4.3	1.45	34,528	0.69	1.3
STOUC CITY, IOWA	70	47,750	282,927	73.9	19.7	6.4	1.33	24,023	0.50	1.2
CHARLESTON, W. VA.	156	46,145	347,190	82.4	13.3	4.3	c/	23,511	0.51	c/
ROANOKE, VA.	75	45,052	284,528	77.3	10.0	12.7	0.74	164,315	3.65	7.8
NORTH DAKOTA	69	42,000	232,597	85.2	12.4	2.4	0.73	2,703	0.06	0.2

^{a/} Combined data for hospital and medical contracts.
^{b/} Includes California Premium Tax of 2.5%.

c/ Data lacking for calculation of this figure.

APPENDIX I

ENROLLMENT IN EACH MEDICAL SERVICE PLAN AS OF JANUARY FIRST, 1940 - 1947

PLAN	DATE OF FIRST ENROLLMENT	1940	1941	1942	1943	1944	1945	1946	1947
OREGON PHYSICIANS SERVICE	1929	a/	a/	a/	a/	a/	108,000*	85,000	92,000*
WASHINGTON (ALL COUNTY PLANS)	1933	a/	a/	a/	a/	a/	200,000*	200,000*	250,000*
CALIFORNIA PHYSICIANS SERVICE	Sep. 1939	7,000	22,000	40,000	75,000*	90,000*	130,000	169,810	419,672
MICHIGAN	MAR. 1940	-	120,974	450,000*	500,000*	608,655	768,755	858,235	850,000
ILLICA, NEW YORK	APR. 1940	-	3,021	8,492	15,557	21,893	30,277	44,695	68,514
BUFFALO, NEW YORK	1940	-	1,146	5,709	9,740	20,089	37,336	61,813	102,438
MEDICAL SERVICE ASS'N., N.C.	1940	-	11,021	13,066	14,200	12,421	30,621	50,890	b/
PENNSYLVANIA	OCT. 1940	-	-	a/	9,000*	10,000*	a/	21,000*	55,000*
CHAPEL HILL, N.C.	AUG. 1941	-	-	5,086	23,770	39,371	63,717	110,907	179,800
SACRAMENTO, CALIF.	1941	-	-	a/	1,959	5,240	10,292	19,042	37,221
COLORADO	MAY 1942	-	-	-	a/	10,620	45,136	95,362	174,132
NEW JERSEY	JUL. 1942	-	-	-	4,131	16,015	31,213	49,441	88,088
OAKLAND, CALIF.	1942	-	-	-	a/	a/	30,000	56,143	116,653
MASSACHUSETTS	1942	-	-	-	a/	22,166	75,770	221,845	461,000
NEW YORK, N.Y.	DEC. 1942	-	-	-	2,262	36,865	77,412	159,473	405,744
DELAWARE	MAY 1943	-	-	-	-	12,008	36,326	69,518	100,983
HOSPITAL CARE ASS'N., N.C.	MAY 1943	-	-	-	-	10,758	34,798	43,832	138,704
KANSAS CITY, MO.	JUN. 1943	-	-	-	-	6,254	27,636	51,746	115,000
CHARLESTON, W. VA.	NOV. 1943	-	-	-	-	3,585	11,000	18,075	27,700
NEW HAMPSHIRE-VERMONT	AUG. 1944	-	-	-	-	-	2,000*	36,863	85,370
HUNTINGTON, W. VA.	1944	-	-	-	-	-	2,001	2,759	3,742
NEBRASKA	NOV. 1944	-	-	-	-	-	500*	5,579	21,540
ST. LOUIS, MO.	1945	-	-	-	-	-	-	20,249	66,849
SYRACUSE, N. Y.	1945	-	-	-	-	-	-	3,500	10,078
NEW ORLEANS, LA.	JUN. 1945	-	-	-	-	-	-	5,227	15,412
OKLAHOMA	JUN. 1945	-	-	-	-	-	-	2,611	20,283
CLEVELAND, OHIO	JUN. 1945	-	-	-	-	-	-	18,367	46,429
IOWA	SEP. 1945	-	-	-	-	-	-	3,145	17,214
ROANOKE, VA.	NOV. 1945	-	-	-	-	-	-	5,258	32,070
ALABAMA	1945	-	-	-	-	-	-	7,018	45,791
TEXAS	1945	-	-	-	-	-	-	10,854	32,242
RICHMOND, VA.	1945	-	-	-	-	-	-	26,792	72,989
KANSAS	JAN. 1946	-	-	-	-	-	-	-	14,558
COLUMBUS, OHIO	FEB. 1946	-	-	-	-	-	-	-	71,895
FLORIDA	1946	-	-	-	-	-	-	-	2,919
INDIANA	1946	-	-	-	-	-	-	-	82,531
LOUISIANA PHYSICIANS SERVICE	1946	-	-	-	-	-	-	-	5,972
MONTANA	1946	-	-	-	-	-	-	-	8,996
NEW MEXICO	1946	-	-	-	-	-	-	-	2,583
NORTH DAKOTA	1946	-	-	-	-	-	-	-	6,185
N.W. HOSPITAL SERVICE, OREGON	1946	-	-	-	-	-	-	-	4,741
ROCHESTER, N. Y.	1946	-	-	-	-	-	-	-	11,700
UTAH	1946	-	-	-	-	-	-	-	4,044
MILWAUKEE, WIS.	1946	-	-	-	-	-	-	-	66,900

a/ Plan in existence but enrollment not obtained
b/ Enrollment Included in Hospital Care Ass'n., N. C.

c/ Enrollment includes Medical Service Ass'n., N. C.
d/ Approximate

APPENDIX J

STANDARDS OF ACCEPTANCE FOR MEDICAL CARE PLANS^{1/} AMERICAN MEDICAL ASSOCIATION

(Preliminary)

Development of plans affecting the distribution of medical care, in accordance with the principles adopted by the House of Delegates, is one of the principal functions of the Council on Medical Service and Public Relations. First in importance in the development of plans affecting the provision of medical care is the utilization of the pre-payment method to help spread medical and surgical costs.

The Council on Medical Service and Public Relations suggests that special recognition be granted to plans organized and operated in accordance with standards which adequately protect the interest of the public and the medical profession.

In granting this recognition the Council will consider each pre-payment medical care plan in the light of established knowledge, authoritative opinion, and according to standards adopted from time to time by the Council in the interest of the public. Plans that conform with the requirements thus formulated will be accepted by the Council.

Under the conditions defined in the following paragraphs, the Council grants the right to print its seal on all official papers of accepted plans and in any promotional literature or display material used by these plans.

This official seal should appear without comment on its significance unless such comment has been previously approved by the Council. A statement proposed for such use follows: "the seal of acceptance denotes that (name of plan) has been accepted within the standards set forth by the Council on Medical Service and Public Relations of the American Medical Association."

The acceptance of a plan and the seal of the Council are intended to signify that the plan conforms with or meets the following standards or requirements:

LOCAL APPROVAL

(1) The prepayment plan must have the approval of the State medical association -- or if local, of the county medical society in whose area it operates.

PROFESSIONAL CONTROL

(2) The medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified legally and by education to accept responsibility for the character of the medical services rendered.

- a. The plan should provide for the appointment of a committee by the medical profession in the area served by the plan, one of the duties of this committee shall be the determination of relative values of medical services and procedures as set forth in the plan's published schedule of benefits, and of those services and procedures not so published.

^{1/} Quoted from Voluntary Prepayment Medical Care Plans, American Medical Association, 1947, p. 91.

- b. The published schedule of benefits of the plan shall include at least all services and procedures commonly performed, a list of which shall be set forth by the Council on Medical Service and Public Relations of the American Medical Association.

ARBITRATION

(3) Provision should be made for a medical director acceptable to the county or State medical society, or a committee appointed by either of these groups, to adjust difficulties and complaints. The medical director or committee members may be paid on a per diem basis for the time involved in handling such matters.

FREE CHOICE OF PHYSICIAN

(4) There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

PATIENT-PHYSICIAN RELATIONSHIP

(5) The method of giving the service must retain the personal, confidential relationship between the patient and the physician.

*(6) The plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of the subscribers, the physicians and the plans are presupposed as necessary considerations for successful operation.

(7) The dues from subscribers through premium rates should be adequate to provide for the benefits offered and the risks involved.

In determining such factors the Council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluations.

STATEMENT OF BENEFITS

(8) These benefits may be in terms of cash indemnity or service units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

(9) Subscribers' contracts must state clearly the benefits and conditions under which medical services will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

* In order to clarify this point further, the Council has adopted the following interpretation of number 6:

The adequacy of the benefits offered to subscribers (or members) shall be based on the following:

1. Percentage of earned income returned to the subscribers, such percentage to include claims paid and reserves for unpaid or anticipated claims.
2. The contractual restrictions and limitations.
3. The interpretation of the benefits provided in the contract.

Further determination of what percentage constitutes an adequate return, of reasonable restrictions and of fair benefit interpretation must necessarily be based on factual data obtained from all medical society approved plans.

As more figures are developed from the operation of plans the Council will have a sound basis for determining a fair return, fair contract, and so on. Ultimately, specific standards can be set forth with reference to all of these.

PROMOTION

(10) Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the Council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the Council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

ENROLLMENT

(11) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

(12) It is understood that the plan of organization will conform with State statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate State authority.

(13) Each accepted plan must submit periodic reports of financial and enrollment experience in the manner prescribed by the Council.

DURATION OF ACCEPTANCE

Acceptance of plans by the Council will be for a period of two years or until revoked (provided they comply with the standards during this period) at the end of which all contracts and financial statements be re-examined. A shorter period of approval may be granted at the discretion of the Council. Any changes in contracts or literature during the period of acceptance must be submitted to the Council for review.

APPENDIX K

COMMERCIAL HOSPITAL, SURGICAL AND MEDICAL EXPENSE INSURANCE

Insurance companies, it is estimated, cover about 12,500,000 persons under hospital expense contracts, about 9,300,000 under surgical expense contracts, and about 850,000 under medical expense policies, i. e., policies covering physicians' home, office and hospital calls. In general, the people covered for the different services are the same, i. e., most of those with the medical coverage also have the surgical and most of those with the surgical coverage also have the hospital coverage.^{1/} This insurance is of two types -- "group" and "individual". About three-fourths of the people covered have the group insurance. The difference in the two types of insurance calls for separate descriptions.

GROUP INSURANCE

A survey by the Life Insurance Association of America covering the group business of 120 life insurance companies and 27 casualty insurance companies (which together were estimated to receive 98.2 percent of 1945 group premiums) found that as of December 31, 1945 a total of 7,800,000 persons were covered for hospitalization, 5,530,000 for surgical expense and 430,000 for medical expense, and that total premiums for all of this business amounted in 1945 to approximately \$90,000,000. (See Table 1) By applying to these figures the percentage increases in coverage during 1946 of five companies which together write well over half of all group hospital and surgical expense insurance it is estimated that at the end of 1946 approximately 9,550,000 persons were covered for hospitalization, 7,300,000 for surgical expense and 550,000 for medical call expense.^{2/}

The bulk of group hospital, surgical and medical expense insurance is written by life insurance companies which write this type of business along with group life, disability, and other types of group insurance. The remainder is written by casualty insurance companies which write group accident and health insurance. The survey by the Life Insurance Association showed that at the end of 1945 the life insurance companies covered 87 percent of those with hospital coverage, the same proportion of those with the surgical coverage and 39 percent of those with medical expense coverage.

A large proportion of the hospital and surgical expense insurance written by life insurance companies -- in 1945 some 85 percent -- is written by the eight companies which were formerly members of the so-called Group Associa-

1/ However, a substantial number of groups have surgical coverage with insurance companies but have hospital coverage with Blue Cross plans.

2/ Of the latter a certain proportion, perhaps about one-fifth, were covered for physicians' calls in the hospital only.

TABLE I

Group Hospital, Surgical and Medical Expense Insurance
Business in Force in the United States as of December 31, 1945.

TYPE OF COVERAGE	NUMBER OF MASTER POLICIES	NUMBER OF CERTIFICATES	NUMBER OF INDIVIDUALS COVERED ^{1/}	TOTAL AMOUNT OF COVERAGE	PREMIUMS AND CONSIDERATIONS DURING 1945
GROUP HOSPITAL EXPENSE					
EMPLOYEE COVERAGE	20,389	4,371,350	4,371,350	\$19,939,000 ^{2/}	35,389,000
DEPENDENT COVERAGE	10,849	1,385,491	3,432,320	13,914,000	20,117,000
TOTAL	XXXX	XXXX	7,803,670	33,853,000	55,506,000
GROUP SURGICAL EXPENSE					
EMPLOYEE COVERAGE	18,936	3,948,565	3,948,565	\$579,081,000 ^{2/}	24,019,000
DEPENDENT COVERAGE	7,350	649,303	1,587,669	207,363,000	8,818,000
TOTAL	XXXX	XXXX	5,536,234	786,444,000	32,837,000
GROUP MEDICAL EXPENSE COVER- AGE					
EMPLOYEE COVERAGE	2,014	335,152	335,152	XXXX	1,363,000
DEPENDENT COVERAGE	508	42,000	97,876	XXXX	489,000
TOTAL	XXXX	XXXX	433,028	XXXX	1,852,000

^{1/} Number of dependents, when unavailable, was estimated by the companies on the basis of 2.5 dependents per dependent unit, i. e., per employee with dependent coverage.

^{2/} Daily benefit

^{3/} Maximum surgical benefit

tion.^{3/} Five of these companies were personally visited in December 1944, and the following description of group hospital, surgical and medical expense insurance is based on information thus derived, supplemented by later correspondence and by correspondence with a number of other large companies writing this type of business.

The larger life insurance companies began to write group hospital expense insurance in 1935-37. At first contracts of this nature were written to supplement group life and disability contracts already in force; the insurance was not sold separately -- latterly it has been. At first coverage was written for employees only. After a few years, in 1936-38, the companies began to write contracts covering dependents as well, and at about the same time they began to offer surgical expense contracts. Originally the companies would only sell the surgical expense contracts where the insured concern had the company's hospital insurance. In recent years however, some of the companies have been willing to sell surgical expense contracts when the insured concern had hospital protection with Blue Cross. In 1940, or thereabouts, the companies began to experiment with medical expense coverage and in 1944-46 began to offer this type of coverage more generally. (The casualty companies have been more adventurous in entering this field than the life insurance companies.) The growth in the number of persons covered by all companies for hospital and surgical expense is shown by Table 2.

TABLE 2

Number of Employees and Dependents Covered Under
Group Hospital and Surgical Expense Insurance, 1935-1946^{1/}
(Data as of December 31st each year)

DATE	NUMBER OF EMPLOYEES COVERED		NUMBER OF DEPENDENTS COVERED ^{2/}	
	HOSPITAL EXPENSE	SURGICAL EXPENSE	HOSPITAL EXPENSE	SURGICAL EXPENSE
1935	38,000	-	-	-
1936	80,773	-	-	-
1937	^{3/}	^{3/}	^{3/}	^{3/}
1938	300,000	93,900	^{3/}	^{3/}
1939	960,000	600,000	^{3/}	^{3/}
1940	1,800,000	1,300,000	^{3/}	^{3/}
1941	2,600,000	2,000,000	1,250,000	^{3/}
1942	3,230,000	2,700,000	1,850,000	575,000
1943	4,300,000	3,800,000	2,500,000	900,000
1944	4,900,000	4,300,000	3,500,000	1,325,000
1945	4,371,350 ^{4/}	3,948,565 ^{4/}	3,432,320	1,587,669
1946	5,333,000	5,015,000	4,220,000	2,287,000

^{1/} Data from 1935 to 1944 inclusive from annual surveys made by the Equitable Life Assurance Society of the U. S. The figures are for both the United States and Canada, the Canadian business being estimated to be about 1½ to 3½ percent of the total. The figures for 1945 are from the survey of the Life Insurance Association of America and are for the United States only. The figures for 1946 are the writer's own rough estimates based on 1946 growth of five of the principal companies.

^{2/} Number of dependents estimated on the assumption of 2½ dependents per dependent unit.

^{3/} Data not obtained.

^{4/} Decrease due to reconversion.

³ Aetna Life Insurance Co., Connecticut General Life Insurance Company, Equitable Life Assurance Society of the U.S., General American Insurance Co., John Hancock Life Insurance Co., Metropolitan Life Insurance Co., Prudential Insurance Co. of America, Travelers Insurance Co.

HOSPITAL EXPENSE POLICIES: BENEFITS AND RATES

All of the companies issue much the same type of policy. It provides a daily room benefit of so many dollars per day of hospital care (under some policies the insured person is entitled to this payment irrespective of the cost of the room actually occupied; under other policies he is reimbursed for the actual room cost up to the amount of the daily benefit) plus reimbursement of actual expenses for the special hospital services (operating room, laboratory, x-rays, drugs, etc.) but not exceeding so many times the daily room benefit. Formerly the companies sold policies with a daily room benefit of from \$2.00 to \$6.00. The \$5.00 benefit rate was the most popular. Since 1945 the companies have indicated willingness to write policies carrying a daily room benefit of as high as \$8.00, but they will write such policies only for concerns in large metropolitan areas and where the plan of insurance carries a graded schedule of daily room benefit, varying more or less with the salary or wage paid the individual employee.^{4/}

Formerly the customary policy provided reimbursement of expenses for the special hospital services of up to an amount equal to five times the daily benefit. Within the last few years the companies have offered alternative contracts at a higher cost providing reimbursement of these expenses up to a limit of 10 times the daily benefit, and some companies offer policies with still higher limits, i. e., 15 or 20 times the daily benefit.

Virtually all the companies provide coverage for either 31 or 70 days per disability. Under most contracts the person must stay in the hospital at least 18 hours to be eligible for benefits. Under the alternative contracts mentioned above, giving greater reimbursement for the special services, it is generally provided that the stay need be only 6 hours in case of surgery or emergency, 18 hours for other cases..

In the matter of hospitalization for maternity, i-e., childbirth or conditions resulting from pregnancy, there is considerable variety in policy provisions. Policies will be written at different rates under which hospitalization for maternity is made available without a waiting period, with a waiting period of nine months, or wherein no benefit is provided. Perhaps the most common arrangement is that in which females employed by the concern on the effective date of the policy are entitled to hospitalization for maternity without a waiting period, but female employees who become insured after the original effective date of the policy are entitled to maternity benefits only after a waiting period of nine months. Where maternity benefits are furnished, under practically all policies, payment of the daily benefit is limited to 14 days, or alternatively all payments for maternity care are limited to an amount not exceeding 10 times the daily benefit. Aside from maternity, coverage is provided for all diseases and conditions other than workmen's compensation.

Hospital benefits for dependents will be written if 75 percent of the employees with dependents take it. Dependents include wife and all unmarried children between 3 months and 18 years of age. Female employees may cover their children but not their husbands. The same benefits are provided except that frequently dependents are insured at a lower daily benefit rate than

^{4/} The purpose of this latter requirement is to avoid "over-insurance" on employees who would customarily take low-cost hospital accommodations.

the employee. Policies will be written with or without maternity benefits for dependent wives. If included, maternity benefits may be made available only after a nine months' waiting period, or for an extra premium payable during the first year they will be made immediately available to dependent wives insured as of the effective date of the policy.

The rates charged by the different companies have some similarity but differ in detail. To avoid complexities the rates of one company will be cited.

The basic premium rate for employees per \$1.00 of daily benefits is 11 cents per month for the 31-day standard plan and 12.2 cents for the 70-day standard plan. This includes immediate maternity benefits for female employees. These rates are for groups containing less than 11 percent of female employees, and where there is no special health hazard. The rates are increased for groups having more than 11 percent of female employees as follows:^{5/}

<u>Percent of Total Benefits For Which Female Employees Are Eligible*</u>	<u>Monthly Cost Per \$1.00 of Daily Benefit</u>			
	<u>Standard Plan**</u>		<u>Alternate Plan**</u>	
	<u>31 Days</u>	<u>70 Days</u>	<u>31 Days</u>	<u>70 Days</u>
Less than 11%	\$.110	.122	.130	.144
11% but less than 21%	.126	.140	.149	.166
21% but less than 31%	.137	.152	.162	.180
31% but less than 41%	.148	.165	.175	.194
41% but less than 51%	.165	.183	.195	.216
51% but less than 61%	.179	.198	.211	.234
61% but less than 71%	.192	.213	.227	.252
71% but less than 81%	.206	.229	.244	.270
81% but less than 91%	.220	.244	.260	.288
91% and over	.234	.259	.276	.306

* Where all employees are insured for the same daily benefit, then the loading is determined in accordance with the percent of female employees. Where employees are eligible for different daily benefits, then the loading is determined as indicated.

** Standard plan provides reimbursement for the special services up to five times the amount of the daily benefit; the alternate plan provides reimbursement for the special services up to 10 times the daily benefit.

Thus, for a group of employees of whom 75 percent are males, the cost per month for a \$5.00 daily benefit under the Standard 31-day Plan would be \$.685.

The above rates apply to groups subject to no particular health hazard and where all conditions are favorable. Additional premiums are required for concerns in industries subject to a health hazard. Examples of the minimum additional premiums required are: breweries and wine manufacturers, tanneries, marble and stone yards, furriers, and textile concerns in certain States, 15%; railroads, woodsmen and loggers, 25 percent; felt hat factories, mines and quarries, 40%.

Rates for dependents may be on a single rate basis -- one rate irrespective of number of dependents; or on a double rate basis -- different charges

^{5/} Some companies make this loading dependent on the percent of both female and non-white employees.

according to whether the insurance covers one dependent or two or more dependents; or on a triple rate basis -- different charges according to whether the insurance covers a wife only, children only, or wife and children. The rates are not subject to loading, i. e., they are uniform irrespective of the health hazard of the industry or the percent of females in the employed group.

Rates on the single rate basis are as follows:

	Monthly Cost Per \$1.00 of Daily Benefit			
	Standard Plan		Alternate Plan	
	31 Days	70 Days	31 Days	70 Days
Maternity Benefits Excluded	.221	.245	.246	.273
"10 times" Maternity Benefits*				
a. Maternity Benefits Deferred				
Nine months	.321	.345	.346	.373
b. Immediate Maternity Benefits	.391	.415	.416	.443
"14-Day Maternity Benefits**				
a. Maternity Benefits Deferred				
Nine months	.371	.395	.396	.423
b. Immediate Maternity Benefits	.481	.505	.506	.533

* All benefits limited to 10 times daily benefit.

** Reimbursement of room charge up to amount of daily benefit for not more than 14 days, plus specified allowances for special services.

The rates for immediate maternity benefits are dropped after the first year to those for maternity benefits after nine months.

Thus, under the Standard Plan and for 31-day coverage, the monthly rate for dependents for a \$5.00 daily benefit, with maternity benefits deferred for nine months and limited in an amount to 10 times the daily benefit, would be \$1.61. For a concern with 75 percent male employees in an industry without special health hazard the total cost of family coverage would therefore be \$2.29.

The above rates are the so-called basic or initial rates. They are subject to retroactive adjustment in the light of the experience not only of the particular group but also of all groups insured by the same carrier. At the end of each year, any excess of premiums over claims, administrative expenses, charges for contingency reserves and other purposes is returned to the employer in the form of a dividend (in the case of mutual companies) or as a retroactive rate reduction (in the case of stock companies). The adequacy or redundancy of the premium rate for each group is also considered each year and as a result the basic or initial rate may be increased if the experience is unfavorable or it may be lowered if the margin between premiums and necessary charges appears too great.

SURGICAL POLICIES: BENEFITS AND RATES

Surgical policies provide for reimbursement of fees incurred for surgical operations (including treatment of fractures) up to the maximum provided in the schedule of operations contained in the policy. Policies are written with or without maternity benefits. Reimbursement will be given for expense for covered services, whether rendered in or out of a hospital, so long as they are performed by a legally qualified practitioner.

The major companies all use a similar standard schedule. This provides reimbursement up to a maximum of \$150 for any one disability. Examples of allowances are: Appendectomy, \$100; tonsilectomy, \$25; single hernia, \$50; two or more hernias, \$75; delivery, (childbirth) \$50. Most policies carry the standard, \$150 maximum, schedule. However, the companies will write, at proportional rates, policies providing for reimbursement up to a maximum of \$75, \$100, \$112.50, \$200 or \$225, the allowances for the individual operations being scaled down or up proportionally. The endeavor is made to sell that schedule which approximates the average fees charged to workers in the community.

In the case of the one company used as an example, the basic monthly cost of the standard \$150 schedule, is 40¢. This is increased for groups with more than 11 percent of the total benefits written on female employees, as follows:

<u>Percent of Total Benefits for Which Female Employees are Eligible</u>	<u>Monthly Cost</u>
Less than 11%	\$.40
11% but less than 21%	.46
21% but less than 31%	.50
31% but less than 41%	.54
41% but less than 51%	.60
51% but less than 61%	.65
61% but less than 71%	.70
71% but less than 81%	.75
81% but less than 91%	.80
91% and over	.85

There is no loading according to the health hazard of the industry. Rates for dependents (single rate basis) are as follows:^{6/}

Obstetrical Benefits Excluded	\$1.20 a month
Obstetrical Benefits Deferred 9 months	1.55
Immediate Obstetrical Benefits	1.90 (this rate drops to \$1.55 after 1st year)

Thus, the rate for an employee and his dependents (with obstetrical benefits for dependents deferred nine months) in insured groups with 75 percent males would be \$2.05 a month.

EMPLOYER CONTRIBUTION

It is customary in all group insurance for the employer to pay part or all of the cost. Some of the companies will not write a group unless the employer makes some contribution towards the cost. One company stated that employers paid all or part of the cost in 88 percent of the groups written in 1943. All of the companies are more insistent about an employer contribution for dependent coverage than for coverage of the employees. In part this is merely a reflection of the fact that, because of the costs involved, the com-

^{6/} These rates apply only where surgical benefits are written in conjunction with hospitalization for dependents and hospital and surgical expense benefits for employees.

panies have found it difficult or impossible to sell dependent hospitalization and especially dependent surgical coverage without the employer paying part of the cost.

The companies require the employer to assume considerable responsibility for the group insurance plan. The insurance contract is made with the employer. The employer does not take out the insurance unless he is thoroughly sold on it, is willing to pay part of the cost and gives the plan his hearty endorsement to employees. It is considered his responsibility to take appropriate steps to get new employees to sign up so that always at least 75 percent of the employees will have the insurance. The companies encourage participating concerns to install procedures which tend to make the taking out of insurance by new employees an automatic procedure handled in a routine fashion at the time other employment papers are signed.

ENROLLMENT REQUIREMENTS AND EMPLOYEE ELIGIBILITY

The minimum size of groups, i. e., number of participating employees, that will be accepted varies among the insurance companies. Some set the minimum at 25, others at 50. At least 75 percent of all eligible employees must participate and companies taking groups as small as 25 may have higher percentage requirements for groups of 25 to 50. In some States these minimum requirements are fixed by law. According to the survey of the Life Insurance Association of America the average size of groups written under employee hospitalization coverage was approximately 215 employees. In general the larger companies tend to write the larger groups. Thus in one company visited the average size of group was 620 members.7/

New employees of concerns having coverage may take out the insurance after they have been with the concern a specified period, frequently three months. The object of this probationary period is to avoid the bother and cost of insuring "floaters" and also to avoid any adverse selection due to people taking employment with a concern for a day or week merely to obtain hospital or surgical coverage. If new employees do not take out insurance during the first month of their eligibility, they can take it out later only after a physical examination showing them to be in good health.

Insurance terminates at the end of the month during which employment is terminated, and there is no conversion privilege. However, if the employee or dependent should be hospitalized or undergo an operation within three months after insurance termination for any reason, and if it is established that the employee was continuously disabled from the date of insurance termination to the date of hospital confinement or the date such operation was performed, full benefits will be payable. Maternity benefits, if included, are available for nine months following date of insurance termination.

7/ One company, in which the average number of employees in its employee hospital expense groups was 412 (at the end of 1945), provides the following data on distribution of these groups according to size:

Size of Group	% of Groups
Less than 100 lives	43
100 - 249	30
250 - 499	13
500 - 749	4
750 - 999	2
1000 - 1999	5
2000 - 4999	2
5000 lives or more	1
	<hr/> 100%

ADMINISTRATION OF CLAIMS

When an employee receives hospitalization or surgery he obtains a claims form from his employer. This form must be filled out and signed by a hospital official and/or the attending physician. The employee then returns the form to his employer who fills out the employer's section of the blank (giving facts with respect to such matters as the employee's employment, effective date of insurance, etc.). Subsequent procedures depend upon the practices of the particular insurance company. Some companies pay all claims through the home office and some use branch claims offices which are located throughout the country. Some companies require the employer to forward all claim papers and the company administers all claims. Some companies permit or require the employer to approve and pay or reject claims; copies of the claims and the check are then forwarded to the insurance company for audit. Other companies use a so-called draft book method under which the employer approves claims which are in order and prepares a draft made out to the employee for the amount of the claim. Then the claim papers, together with the draft advice, are forwarded to the insurance company by the employer. The insurance company reviews the papers and gives final approval of the claim. The employer does not have the right to reject any claim. He forwards the claims which he thinks should be rejected to the insurance company without preparing a draft and the approval or rejection of such claims rests solely with the insurance company.

In the case of many of the large groups, the employer keeps all application cards and records. The only data sent to the insurance company is the number of employees covered each month and the premiums due. The insurance company has no idea which employees are in good standing; however, the insurance company has the right to audit the account whenever it wishes to do so. Any minor error in computing the number of employees covered and the premiums due is almost automatically adjusted in the dividend or rate reduction.

In some of the larger groups the employer rejects or accepts all claims, sending a copy of the claim and the check (or draft) to the insurance company. Here again the insurance company has the right to audit the account, but the real control is that if the employer pays unjustified claims, the excess claim payments will automatically reduce his dividend or rate reduction -- on the other hand, failure to pay all proper claims would presumably result in employee dissatisfaction which would soon be brought to the attention of the insurance company, which is directly liable for the payment of claims whether or not the work of initially paying claims has been delegated to the employer.

If the claim has a receipted bill attached, the check is made out to the claimant only. Some companies, if the claim indicates that the bill has not been paid, make out the check jointly to the hospital or physician and the claimant, and the check is sent to the claimant. The companies visited stated that in from 25 to 50 percent of hospital claims the claimant signs a statement assigning his claim to the hospital. In these cases the check is made out to the hospital or to the hospital and the claimant jointly. The companies stated that in only about five percent of surgical claims is there an assignment of the claim to the physician. The reason for this difference is that hospitals are more insistent than physicians on having immediate payment of the bill, and that physicians are more reluctant than hospitals to insinuate, by asking for an assignment, that the patient may not be good for

the amount of the charge.

The officials of one large company, which administers all claims through the home office, stated that the vast majority of claims -- probably 95 percent -- are handled within 24 hours of receipt. Persons located close to New York would thus receive a check within three or four days of the mailing of their claim. For persons located, say, in Texas there might well be an interval of a week or more.

MEDICAL CALLS

The companies are interested to a certain extent in the possibilities of insurance covering office, home and hospital calls, and there is a growing demand for this type of protection from employers and employees. In the past there has been considerable hesitation on the part of insurance companies to offer this coverage but many of the companies have had experimental plans in effect for some time, and some are now prepared to offer this insurance on a large scale.

There is considerable variety in the types of plans or policies being offered. A number of the present contracts are limited to employees and are on a two-visit deductible basis, i. e., benefits are not provided for the first two calls in any illness. Two dollars are paid for an office or hospital call and three dollars for a home call. One company charges a basic monthly rate of \$.50 per employee for this coverage. Reimbursement is provided for only one visit per day, and there is no limit on the number of visits in any one year. Visits are only paid for in the case of total disability. The same company offers a "comprehensive" plan which covers all visits including the first. Total disability is not required. The basic charge is \$.90 per month for the employee, and \$2.60 per month for dependents. Dependents are limited to 50 visits in any one calendar year.

Within the last two years a number of companies have offered coverage of physicians' calls for hospitalized medical cases, home and office visits being excluded. One company offers this at a rate of \$.035 per month per dollar of daily in-hospital medical expense benefit, e. g., \$.105 per month for a benefit while hospitalized of \$3.00 a day. Actual charges for doctors visits will be paid up to the amount of the benefit times the number of days of hospitalization, not in excess of 50 days.

In the past some of the executives of some of the larger companies have expressed doubt that insurance companies would find it possible successfully to write insurance covering home and office calls. Their feeling was that without controls over the number of calls that might be demanded by patients or provided by physicians such calls would not constitute an insurance risk. Be that as it may, many of the insurance companies are now prepared to write this insurance on a large scale.

FINANCIAL EXPERIENCE

Separate financial data for hospital, surgical and medical expense insurance are not available; the only data available are those for so-called group accident and health insurance which includes this class of business combined with weekly indemnity disability insurance. Since approximately half of the total premiums for all group accident and health insurance are

for hospital, surgical and medical expense benefits, and since presumably the companies endeavor to make about the same net gain on this business as on the weekly indemnity disability insurance, it is probable that the financial showing for the combined business gives a good indication of the showing for hospital, surgical and medical expense insurance by itself.

In 1945 the total earned premiums for all group accident and health insurance amounted to \$208,856,894.^{8/} Claim payments amounted to 73.9 percent, expenses of administration to 13.8 percent, leaving a net gain from underwriting of 12.3 percent. From the net gain from underwriting a certain amount was paid back to the policy holders by the mutual companies in the form of dividends.

The figures for seven large companies which together write close to three-fourths of all group hospital and surgical expense insurance are as follows:^{9/}

<u>Company</u>	<u>Earned Premiums</u>	<u>Losses Incurred incl. Adjustment Expenses</u>	<u>Underwriting Expenses Incurred</u>	<u>Dividends Paid to Policy holders</u>	<u>Net Income and/or Additions to Reserves</u>
Stock Companies					
A	\$29,573,205	82.0	12.2	-	5.8
B	8,918,803	83.9	12.8	-	3.3
C	27,802,786	84.7	12.0	-	3.3
Mutual Companies					
D	24,899,154	67.9	10.3	16.5	5.3
E	10,513,994	64.8	19.4	10.1	5.7
F	46,271,945	70.8	10.6	12.2	6.4
G	13,194,603	67.0	12.9	14.3	5.8

In the above data, "losses incurred including adjustment expenses" include the administrative expenses of paying claims, which expenses probably range from 2 to 5 percent of premiums. These expenses would be added to "underwriting expenses incurred" to obtain total administrative expense.

One large mutual company reports that under its hospital and surgical expense policies, claims amounted to 60.3 percent of premium income and dividends to 20.8 percent, a total return to the groups of 81.1 percent of premiums.

^{8/} Spectator Pocket Register of Accident Insurance, 1946. The Spectator Company, Philadelphia, 1946.

^{9/} Data from Spectator Pocket Register of Accident Insurance, 1946, plus statement by one company as to the dividends paid by this and the other companies on this type of business.

Another mutual company reports the following financial experience for the year 1945, the data covering insurance on both employees and dependents:

Ratio to Premiums

	Hospital Expense Insurance %	Surgical Operation Insurance %
Claims	60	63
Expenses	16	14
Dividends	20	14
Remainder for Additions to Reserves	4	9
Total	100	100

In comparing the administrative expense ratios of the insurance companies with the Blue Cross plans (see Chapter 10), the following factors must be borne in mind: that all of the companies pay a 2.5 percent premium tax; that the insurance companies do not take the small groups that the Blue Cross plans accept, and neither accept individuals nor permit individuals to continue their insurance after leaving groups; and that a considerable amount of administrative work is thrown back upon the employer.

INDIVIDUAL INSURANCE

A large number of insurance companies, mainly casualty companies with an accident and health line, write hospital surgical, and medical call insurance on an individual basis. These companies do not forward to any central source figures on the number of policies issued or persons covered, and in the reports made to State Insurance Departments, financial data for this insurance are merged with those for accident and health (disability) insurance. For these reasons it is difficult to secure trustworthy information as to the extent of coverage of this insurance. On the basis of data obtained from some of the leading companies in this field, it is estimated that as of January 1, 1947, about 3,000,000 persons were covered for hospitalization, about 2,000,000 for surgical expense, and about 300,000 for medical call expense. This insurance has been growing rapidly and these estimates may be quite wide of the mark. The figures relate only to persons who have some appreciable coverage against these expenses. There are many millions of persons holding commercial health and accident policies providing for weekly or monthly payments, often \$50 or \$100 a month, in the event of disability due to illness or accident alone. Many of these policies provide that an extra payment, usually one-half of the regular indemnity, will be paid for any period during which the policy holder is in a hospital. In most instances this would mean that the policy holder would be entitled to about \$1.00 or \$2.00 for each day in the hospital -- a payment so small as to mean negligible coverage of the hospital bill.^{10/}

^{10/} Nor do the above mentioned figures purport to include persons holding accident policies many of which provide quite comprehensive coverage of hospital, surgical and nursing expense resulting from accidents.

Hospital insurance policies sold on an individual basis provide so many dollars for each day in the hospital and allowances of up to stipulated amounts against charges for use of operating room, laboratory services, x-rays, etc.

The policies sold differ so widely in detail that it is difficult to summarize them in any meaningful fashion. The policies of some of the companies which are believed to lead in point of persons covered will be described.

Company A, which is by far the largest company in this field, sells a hospital, surgical and medical expense supplement to its disability policies. This provides a payment of a stipulated amount per day (varies with premium charged) for up to a maximum of 90 days of hospital care in each disability; reimbursement for surgical expense of from \$10 to \$30 varying with length of hospital stay; allowances of \$10 for use of operating room, \$10 for anesthesia and \$5.00 for x-rays; \$3.00 for each physician's visit in the hospital, not to exceed 10 weeks in any 12 consecutive months. Indemnification is only for accidents, and for diseases originating after the supplement has been in force 30 days. No indemnity is provided for any expense because of hernia, childbirth, pregnancy or any complication arising therefrom, or which is payable under any workmen's compensation law. The charge for this supplement is \$1.25 a month per person (\$5.00 a day hospital benefit).

The same company has more recently offered a separate hospital and surgical expense policy. This provides a daily benefit of from \$3.00 to \$7.00 for 90 days of hospitalization per sickness or accident, with complete coverage of charges for operating room, hypodermics, surgical dressings and routine medicines, and with allowances of \$5.00 per admission for laboratory service, \$10 per administration of anesthesia, \$10 for x-rays per admission and \$10 for use of oxygen per admission. This is available with or without surgical coverage, three schedules with maximums of \$75, \$100 or \$150 per operation being offered. The charge for this policy with a \$5.00 daily benefit and the \$150 surgical schedule is \$24.90 a year per adult. Children between the ages of 3 months and 18 years may be added to the parent's policy for one-half the premium. There is an initial \$2.00 policy fee. The policy does not cover sickness resulting in a surgical operation until the policy has been in force six months. It does not cover childbirth, pregnancy or miscarriage, and tuberculosis, heart trouble or hernia will be covered only if originating six months after the policy has been in force.

The applicant is required to state whether he is now in good health and to give the particulars concerning all operations to which he has been subject and all medical treatment received within the last two years, and the policy is written entirely in reliance upon the written answers to these questions and hence may be voided if any such answers are incorrect.

Company B sells a policy which provides a daily hospital benefit of from \$4.00 to \$6.00 for the husband, a benefit of \$4.00 or \$5.00 for the wife and \$3.00 or \$4.00 for each child. These are payable at full rate for the first 30 days of hospitalization, thereafter at half rate for an additional 90 days. Surgical expense is reimbursed according to either a \$100 or \$150 maximum schedule. Expense for the special hospital services will be reimbursed up to four times the daily hospital benefit. Care will be furnished for maternity after a waiting period of 10 months, up to a limit of 10 days. Indemnity is payable in cases of appendicitis, tonsillitis, adenoids, hernia, and condi-

tions involving the female generative organs only after the policy has been in effect 10 consecutive months. The policy covers hospital and surgical expense arising from injury incurred while the policy is in force and from sickness commencing after the policy has been in force for 30 days. There is an enrollment charge of \$5.00 for this policy. The monthly cost of this protection (\$150 surgical schedule) would be \$2.10 for the husband (\$6.00 daily benefit), \$2.25 for the wife (\$5.00 daily benefit) and \$1.60 for each child (\$4.00 daily benefit). This policy is sold with an application which requires the applicant to give all details of illness suffered by himself or members of the family during the last five years, and all particulars concerning any illness from a long list of diseases. The applicant agrees that the falsity of any answer in the application shall bar all right to indemnity, if such answer materially affects either the acceptance of the risk or the hazard assumed by the company.

The writing of hospital and surgical insurance on an individual basis compels the use of safeguards to guard against adverse selection of risks. An unscrupulous company can use these safeguards to make it difficult for policy holders to collect on legitimate claims.

Certain companies operating in this field offer policies so hedged around with exceptions and exclusions -- the importance of which are often not understood by the policy holder -- that their activities are of dubious value to the public. There may be cited as an example a Delaware company which advertizes largely in other States and sells its policies by mail. The prospect, enticed by the seemingly large benefits and low cost of the insurance offered, writes in for information. He receives an application blank which gives no idea of the limitations of the policy, and only after he has forwarded this application together with his first month's premium, does he receive the policy. Only then does he learn what he has really bought. If dissatisfied, he may return the policy within 10 days and secure a refund of his premium.^{11/}

FINANCIAL DATA

No separate data for individual hospital, surgical and medical expense insurance are available. The only data published by the companies or made available in their reports to State insurance departments are those covering all accident and health insurance. However, these combined figures undoubtedly give a good clue as to the financial showing as regards the type of in-

^{11/} This policy provides a daily hospital benefit of \$5.00 plus restricted allowances for the special services, together with indemnification of surgeon's fees and medical calls in the hospital. Coverage is effective in case of accidents from the effective date of the policy; however, in the case of sickness, no benefits are payable within 60 days and only half benefits within the next 120 days. Only those between 17 and 45 years of age are eligible for 100 percent benefits. Minors receive only 50 percent benefits, and those over 45 years of age receive less than full benefits depending upon age. Benefits are not payable in the case of any illness or condition not common to both sexes, and no benefits are payable for a tonsillectomy, adenoidectomy or appendectomy until the policy has been in force six months. This company returns 82 percent of income to its policy holders in the form of benefits and spends 50 percent for administrative expenses.

insurance under discussion. The figures for several companies with large premium volume are as follows: ^{12/}

Company	1945 Earned Premiums	Ratio of losses incurred, including adjustment ex- pense, to earned premiums	Ratio of under- writing expenses to premiums written
		%	%
A	\$47,939,928	58.8	33.8
B	17,338,064	42.6	47.5
C	6,243,903	38.9	51.7

The total earned premiums of all individual accident and health business in 1945 amounted to \$389,000,000; losses incurred including expense of paying claims amounted to 39.7 percent, and underwriting expenses (calculated as a percent of premiums written) to 44.7 percent. The net gain from underwriting was approximately 15.6 percent.^{13/} It is evident that an outstanding characteristic of this type of insurance is the low proportion of premium income returned to the policy holder in the form of benefits, and the high percentage used for selling and administrative expense. Undoubtedly the same holds true for the hospital, surgical and medical expense share of this business.

^{12/} Spectator, Op. cit.

^{13/} A survey of all accident and health insurance business showed that in the period 1938-42 companies specializing in accident and health insurance business had a loss ratio of 51 percent. On the "hospitalization" part of this business, the average loss ratio was 55 percent. (Blanchard, Ralph, H., Survey of Accident and Health Insurance, Bulletin No. 1, 2 and 3. Bureau Memorandum No. 62, Bureau of Research and Statistics, Social Security Board, Washington, D. C., November 1945.

APPENDIX L

FINANCIAL DATA, BLUE CROSS PLANS, 1946 (Includes Plans in Canada and Puerto Rico) Data from the Blue Cross Commission

PLAN	NUMBER OF PARTICIPANTS 1-1-47	TOTAL INCOME 1946	PERCENT OF TOTAL INCOME USED FOR			TOTAL RESERVES 12-31-46	RESERVES PER PARTICIPANT 12-31-46 a/
			HOSPITALIZATION	ADMINISTRATION	RESERVES		
500,000 OR MORE PARTICIPANTS		\$	%	%	\$	\$	\$
NEW YORK, N. Y.	2,779,811	21,082,949	79.52	13.10	7.38	12,628,320	4.54
BOSTON, MASS.	1,991,000*	12,904,002	88.18	15.81	-3.99	2,680,301	1.35
CHICAGO, ILL.	1,178,584	8,315,303	98.08	13.60	-11.68	1,006,419	.85
DETROIT, MICH.	1,167,365	11,535,955	82.33	9.93	7.74	1,299,185	1.11
PHILADELPHIA, PA.	1,062,207	7,048,192	81.07	13.45	5.48	3,323,227	3.13
PITTSBURGH, PA.	1,047,691	6,672,438	79.45	11.38	9.17	2,541,575	2.43
CLEVELAND, OHIO	970,000b/	6,568,932	87.26	7.33	5.41	1,642,513	1.69
NEWARK, N. J.	929,915d/	6,917,721	73.73	12.22	14.05	4,146,313	4.46
ST. PAUL, MINN.	757,489*	4,099,456	81.41	13.12	5.47	1,350,320	1.78
ST. LOUIS, MO.	755,153	4,363,673	84.95	14.27	.78	1,773,166	2.35
TORONTO, ONT.	747,915	3,767,728	71.88	12.21	15.91	1,589,648	2.13
NEW HAVEN, CONN.	650,000*	5,416,897	90.54	7.88	1.58	1,581,942	2.43
CINCINNATI, OHIO	639,920	4,500,807	89.60	10.26	.14	989,055	1.55
MILWAUKEE, WIS.	589,200*c/	3,012,483	88.52	13.40	-1.92	273,524	.47c/
SUBTOTALS - 14 PLANS	15,266,250	106,206,536	83.80	12.26	3.94	36,825,508	2.41
200,000 - 500,000 PARTICIPANTS							
PROVIDENCE, R. I.	463,362	3,011,815	74.36	9.15	16.49	1,568,311	3.38
BALTIMORE, MD.	440,575*	2,920,941	68.77	11.45	19.87	2,804,386	6.37
BUFFALO, N. Y.	421,002*	2,598,310	72.71	14.97	12.32	712,018	1.69
DENVER, COLO.	415,757	2,274,718	79.14	10.51	10.35	863,083	2.08
DES MOINES, IA.	344,061	2,419,285	80.65	14.25	5.10	136,292	.40
ROCKFORD, ILL.	326,992	814,953	82.93	14.02	3.05	160,152	.49
ROCHESTER, N. Y.	313,364*	2,347,147	81.79	11.63	6.58	775,825	2.48
CHAPEL HILL, N. C.	313,000*	1,854,460	74.66	21.32	4.02	539,661	1.72
LOS ANGELES, CAL.	304,735	1,966,988	78.97	16.85d/	4.18	325,134	1.07
WASHINGTON, D. C.	296,300d/	1,913,907	82.29	15.02	2.69	1,438,031	4.85
HARRISBURG, PA.	291,585*	1,674,044	85.45	11.56	2.99	537,850	1.84
MONTREAL, QUE.	277,376*	1,585,255	77.09	15.70	7.21	216,014	.78
TOLEDO, OHIO	262,797*	1,687,807	80.92	11.20	7.88	600,219	2.28
MARITIME PROVINCES	235,342	880,608	79.47	14.64	5.89	75,110	.32
WINNIPEG, MAN.	231,426	1,127,639	89.42	13.71	-3.13	118,028	.51
SYRACUSE, N. Y.	231,021	1,409,756	82.41	13.11	4.48	743,856	3.22
INDIANAPOLIS, IND.	224,990	1,366,119	84.52	12.95	2.53	37,140	.17
TOPEKA, KAN.	217,548	1,258,097	77.23	16.73	6.04	50,828	.23
DALLAS, TEXAS	215,660	1,252,073	76.12	20.57	3.31	179,884	.83
SUBTOTALS - 19 PLANS	5,826,893	34,363,922	78.47	13.76	7.77	11,881,822	2.04

APPENDIX L (Continued)

100,000 - 200,000 PARTICIPANTS	197,249	1,171,360	84.14	13.76	2.10	154,388	.78
CONCORD, N. H.	196,421*	2,008,717	84.59	14.30e/	1.11	717,642	3.65
OAKLAND, CAL.	195,371*	1,097,317	78.38	11.24	10.38	374,267	1.92
WILKES-BARRE, PA.	194,400	1,111,474	78.35	16.48	5.17	551,379	2.84
COLUMBUS, OHIO	190,000*	1,116,044	84.35	14.67	.98	288,538	1.52
PORTLAND, ME.	185,000*	1,031,414	85.66	14.70	-.36	386,431	2.09
KANSAS CITY, MO.	182,110	905,788	91.94	14.17	-6.11	78,386	.43
LOUISVILLE, KY.	181,984	1,302,685	75.84	10.31	13.85	1,008,066	5.54
ALBANY, N. Y.	175,076	1,344,821	99.45	6.28	-5.73	277,726	1.59
YOUNGSTOWN, OHIO	174,822	1,390,113	68.99	17.63	13.38	954,559	5.46
BIRMINGHAM, ALA.	170,597	848,765	78.00	16.91	5.09	128,752	.75
TULSA, OKLA.	155,424	1,035,035	80.59	15.92	3.49	430,011	2.77
RICHMOND, VA.	148,423	1,068,144	92.22	6.61	1.17	231,067	1.56
AKRON, OHIO	144,544*	1,234,799	68.49	31.58	-.07	217,324	1.50
DURHAM, N. C.	139,214*	918,762	78.68	9.43	11.89	563,392	4.05
ALLENTOWN, PA.	136,049*	720,919	75.50	15.21	9.29	353,380	2.60
UTICA, N.Y.	130,956*	869,578	84.47	11.98	3.55	499,238	3.81
WILMINGTON, DEL.	126,477	786,253	78.90	16.96	4.14	478,759	3.79
NEW ORLEANS, LA.	123,556	921,226	96.40	11.25	-7.65	6,293	.05
PEORIA, ILL.	104,178d	709,719	99.85	7.72	-7.57	153,734	1.48
CANTON, OHIO	102,052	366,710	64.19	26.45	9.36	61,907	.61
CHATTANOOGA, TENN.	101,192	512,172	83.59	9.79	6.62	50,762	.50
VANCOUVER, B.C.							
SUBTOTALS - 22 PLANS	3,455,095	22,471,815	82.62	14.11	3.27	7,966,001	2.31
50,000 - 100,000 PARTICIPANTS	99,680	478,921	84.06	9.52	6.42	113,543	1.14
ALTON, ILL.	93,817*	905,144	92.02	18.19	-10.21	-58,618	-.62
SEATTLE, WASH.	80,907	451,467	75.27	20.12	4.61	91,713	1.13
OMAHA, NEB.	75,794	295,228	70.12	13.29	16.59	50,533	.67
SALT LAKE CITY, UTAH	73,735	392,994	69.59	25.92	4.49	-5,014	-.07
JACKSONVILLE, FLA.	64,019	558,313	74.01	17.44	8.55	71,220	1.11
PORTLAND, ORE.	61,010	422,479	76.97	17.88	5.15	40,694	.67
SIOUX CITY, IOWA	57,970	424,969	78.74	10.96	10.30	57,736	1.00
CHARLESTON, W. VA.	55,243	320,410	70.33	21.55	8.12	14,895	.27
HELENA, MONT.	54,429	354,813	85.69	6.91	7.40	186,712	3.43
ROANOKE, VA.	52,955	302,741	77.48	13.32	9.20	30,376	.57
FARGO, N. D.	51,933*	584,039	65.00	21.16f/	13.84	263,351	5.07
SACRAMENTO, CAL.							
SUBTOTALS - 12 PLANS	821,492	5,491,518	77.80	16.74	5.46	857,141	1.04
UNDER 50,000 PARTICIPANTS	49,862	305,562	85.31	11.73	2.96	133,211	2.67
LIMA, OHIO	49,536	383,860	73.09	11.58	15.33	252,496	5.10
ATLANTA, GA.	37,142	318,763	96.97	12.81	-9.78	20,101	.54
NORFOLK, VA.							

* Estimate
 d December 31, 1946
 e/ 2.48 % is State premium tax
 f/ Includes 1.64 % California and Nevada State premium tax

APPENDIX L (Continued)

PLAN	NUMBER OF PARTICIPANTS 1-1-47	TOTAL INCOME 1946	PERCENT OF TOTAL INCOME USED FOR			TOTAL RESERVES 12-31-46	RESERVES PER PARTICIPANT 12-31-46a/
			HOSPI-TALIZATION	ADMINIS-TRATION	RESERVES		
UNDER 50,000 PARTICIPANTS		\$	%	%	%	\$	\$
HUNTINGTON, W. VA.	37,068	225,484	78.07	23.33	- 1.40	57,238	1.54
PHOENIX, ARIZ.	35,432	203,287	61.49	20.83	17.68	53,743	1.52
SAN JUAN, P. R.	33,090	197,265	66.33	17.54	16.13	20,475	.62
KINGSFORT, TENN.	31,665*	149,054	96.94	13.56	-10.50	58,850	1.86
DECATUR, ILL.	30,848	191,288	88.32	11.72	- .04	92,919	3.01
JAMESTOWN, N. Y.	27,767*	169,398	85.22	14.75	.03	82,366	2.97
BOISE, IDAHO	25,233*	45,489	58.72	36.16	5.12	12,342	.49
PORTSMOUTH, OHIO	22,768	147,862	81.92	12.40	5.68	49,881	2.19
SAVANNAH, GA.	21,234	168,406	84.97	12.12	2.91	38,838	1.83
NEWPORT NEWS, VA.	18,334	130,838	90.68	12.24	- 2.92	27,786	1.52
ALEXANDRIA, LA.	16,041	105,757	88.66	20.54	- 9.20	34,444	2.15
ASHLAND, KY.	14,610	89,150	91.25	13.86	- 5.11	26,950	1.84
BATON ROUGE, LA.	14,101	74,369	68.42	16.09	15.49	25,996	1.84
WATERTOWN, N. Y.	13,607	76,500	76.06	12.50	11.44	56,932	4.18
DANVILLE, ILL.	11,760	76,466	83.63	12.12	4.25	16,092	1.36
ALBUQUERQUE, N. M.	8,683	35,935	53.52	52.49	- 6.01	375	.04
LYNCHBURG, VA.	7,913	44,644	74.95	20.13	4.92	24,046	3.04
SUBTOTALS - 20 PLANS	506,694	3,139,377	81.24	15.36	3.40	1,085,081	2.14
GROUP 1 (OVER 500,000 PART.)	15,266,250	106,206,536	83.80	12.26	3.94	36,825,508	2.41
GROUP 2 (200,000 - 500,000 PART.)	5,826,893	34,363,922	78.47	13.76	7.77	11,881,822	2.04
GROUP 3 (100,000 - 200,000 PART.)	3,455,095	22,471,815	82.62	14.11	3.27	7,966,001	2.31
GROUP 4 (50,000 - 100,000 PART.)	821,492	5,491,518	77.80	16.74	5.46	857,141	1.04
GROUP 5 (UNDER 50,000 PART.)	506,694	3,139,377	81.24	15.36	3.40	1,085,081	2.14
TOTAL 87 PLANS	25,876,424	171,673,168	82.34	13.01	4.65	58,615,533	2.27

* Estimate

a/ Based on January 1, 1947 enrollment, and reserves as of December 31, 1946

g/ 9-1-46 through 12-31-46

APPENDIX M

List of Medical Service Plans in the United States, January 1, 1947, Giving Address of Plan and Name of Executive Director

- Note: * Same plan provides medical and hospital service. See list of Blue Cross Plans for address of plan and name of executive director.
- # Plan has same address as affiliated Blue Cross plan, and same individual serves as executive director of both. See list of Blue Cross plans.
- o Plan has same address as affiliated Blue Cross plan.

ALABAMA

Hospital Service Corporation of Alabama*

CALIFORNIA

Hospital Service of California*
Intercoast Hospitalization Insurance
Ass'n*
California Physicians' Service
135 Kearney Street
San Francisco -8
W. M. Bowman, Director

COLORADO

Colorado Medical Service, Inc. #

DELAWARE

Group Hospital Service*

FLORIDA

Florida Medical Service Corp. #

INDIANA

Mutual Medical Insurance, Inc. #

IOWA

Iowa Medical Service
222 Insurance Exchange Building
Des Moines -7
Edwin M. Kingery, Director

KANSAS

Kansas Physicians' Service #

LOUISIANA

Hospital Service Ass'n. of New Orleans*
Louisiana Physicians Service, Inc.
Room 103; 1430 Tulane Avenue
New Orleans
Frank Lais, Jr., Executive Director

MASSACHUSETTS

Massachusetts Medical Service #

MICHIGAN

Michigan Medical Service o
Jay Ketchum, Secretary

MISSOURI

Surgical Care, Inc. of Kansas City #
Missouri Medical Service #

MONTANA

Montana Physicians Service
P. O. Box 1181
Helena
Samuel English, Executive Director

NEBRASKA

Nebraska Medical Service #

NEW HAMPSHIRE

New Hampshire-Vermont Physician Service #

NEW JERSEY

Medical Surgical Plan of New Jersey o
Dr. Norman Scott, Medical Director

NEW MEXICO

New Mexico Physicians' Service o
L. J. LaGrave, Executive Director

NEW YORK

Western New York Medical Plan, Inc.
(Buffalo) #
United Medical Service (New York City) #
Genesee Valley Medical Care, Inc.
(Rochester) #
Central New York Medical Plan, Inc.
(Syracuse) #
Medical and Surgical Care, Inc. (Utica) #

NORTH CAROLINA

Hospital Saving Association of North
Carolina, Inc.*
The Hospital Care Association, Inc.*
Medical Service Association, Inc.
(Durham) #

NORTH DAKOTA

North Dakota Physicians Service #

OHIO

Medical Mutual of Cleveland o
Eugene L. Martin, Director
Ohio Medical Indemnity, Inc.
1328 Huntington Bank Building
Columbus -15
Charles H. Coghlan, Executive
Vice President

OKLAHOMA

Oklahoma Physicians' Service#

OREGON

Oregon Physicians Service
471 Pittock Block
Portland -5
Willard C. Marshall, General Manager
Northwest Hospital Service*

PENNSYLVANIA

Medical Service Association of
Pennsylvania
222 Locust Street
Harrisburg
Lester H. Perry, Executive Director

TEXAS

Group Medical and Surgical Service#.

UTAH

Medical Service Bureau of the Utah State
Medical Ass'n., Inc.
610 McIntyre Building
Salt Lake City
W. H. Tibbals, Executive Secretary

VERMONT

See New Hampshire

VIRGINIA

Virginia Medical Service Association
(Richmond)#
Surgical Care, Inc. (Roanoke)#

WASHINGTON

Various county plans are coordinated
through
Washington State Medical Bureau
Security Building
Olympia, Washington
James P. Neal, Executive Vice
President

WEST VIRGINIA

Medical Service, Inc. (Charleston)#
Huntington Hospital Service, Inc.*

WISCONSIN

Surgical Care#



